MARC E. LIEBERMAN, M.D., F.A.C.S.
CONFIDENTIAL PATIENT INFORMATION

Patient's Name (First, Middle, Last)	Sex ☐ M ☐ F	Marital Status ☐ S ☐ M ☐ W ☐ D	Date of Birth	Social Security Number (mandatory)

Permanent Address (Street, City, State, Zip Code)	Home Phone
	Cell Phone
Seasonal/Temporary Address (Street, City, State, Zip Code)	Home Phone
	From Date To Date
Email Address	Who can we thank for referring you to our office?
Employer (Company Name)	Work Phone / Calls okay? ☐ Yes ☐ No

Name of person financially responsible (First, Middle, Last)	Social Security #	Date of Birth	Relationship to Patient

Address (Street, City, State, Zip Code)	Home Phone
	Cell Phone
If married, spouse's name (First, Middle, Last)	If patient is a minor, name of parent/guardian
Name of person who does not live with patient to contact in an emergency	Relationship to patient / Phone
If we need to contact you, where can we call? ☐ Home ☐ Cell ☐ Work	Can we leave a voicemail? ☐ Yes ☐ No

Can we leave a message with other members of the household? ☐ Yes ☐ No

If yes, list names

Name of Referring Physician	Name of Primary Care Physician

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MEDICAL HISTORY

Name: _____ Date of Birth: _____

Preferred Pharmacy and Location: _____

Reason for Visit Today & Date of Onset: _____

_____

GOVERNMENT REGULATIONS REQUIRE THAT WE ASK

Primary Language
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Other

Race
- ☐ White
- ☐ Black
- ☐ Other

Ethnicity
- ☐ Non Hispanic
- ☐ Hispanic
- ☐ Other

MEDICAL HISTORY **(check Y box for yes)**

Y Cardiovascular:
- ☐ High Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Coronary Artery Disease
- ☐ Atrial Fibrillation

Pulmonary:
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea

Metabolic / Endocrine:
- ☐ Diabetes Type: _____
- ☐ Hypothyroidism

Neurologic:
- ☐ Migraine
- ☐ Stroke/TIA Year: _____
- ☐ Dementia
- ☐ Alzheimer's

Y Ear / Nose / Throat:
- ☐ Hearing Loss
- ☐ Use Hearing Aids
- ☐ Chronic Ear Infections
- ☐ Chronic Sinusitis
- ☐ Nasal Polyps
- ☐ Chronic Tonsillitis

Musculoskeletal:
- ☐ Arthritis
- ☐ Osteoporosis

Genitourinary:
- ☐ Renal Failure
- ☐ Kidney Stones

Oncology:
- ☐ Cancer

Type: _____

Y Ophthalmology:
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

Gastrointestinal:
- ☐ IBS
- ☐ Hepatitis Type:____
- ☐ Gastroesophageal Reflux (GERD)

Infectious Disease:
- ☐ MRSA
- ☐ Mononucleosis

Others Not Listed Above: _____

_____

Past Surgical History (list with year): _____

_____

Past Hospitalizations (if different from surgery, list with year): _____

_____

FAMILY HISTORY

Father: ☐ Alive ☐ Deceased at age _____ Cause of death _____

Mother: ☐ Alive ☐ Deceased at age _____ Cause of death _____

Children: ☐ No ☐ Yes Number of Sons _____ Number of Daughters _____

FAMILY HEALTH HISTORY

On the line next to the condition, specify:
M for Mother, F for Father, B/S for Sibling, CH for Child

Alzheimer's Disease _____
Arthritis _____
Cancer _____
Type _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Parkinson's Disease _____
Respiratory Disease _____
Other _____

☐ **NO FAMILY HEALTH PROBLEMS**

REVIEW OF SYSTEMS - YOUR CURRENT MEDICAL SYMPTOMS (check Y for yes)

Y General:
☐ Fever
☐ Chills
☐ Weight Gain
☐ Weight Loss

Nose & Sinus:
☐ Sneezing
☐ Runny Nose
☐ Postnasal Drip
☐ Congestion
☐ Facial Pain
☐ Nosebleeds

Cardiology:
☐ Chest Pain or Pressure
☐ Shortness of Breath
☐ Swelling - Legs/Ankles/Feet
☐ Pain/Cramping in Legs
☐ Palpitations/Arrythmia

Hematology/Lymphatic:
☐ Abnormal Bleeding
☐ Bruise Easily
☐ Anemia

Endocrine:
☐ Cold Intolerance
☐ Excessive Thirst
☐ Neck Enlargement

Y Allergy/Immunology:
☐ Seasonal Allergies
☐ Bee/Wasp Sting Allergy
☐ Receive Allergy Shots

Throat:
☐ Sore Throat
☐ Sores in Mouth
☐ Difficulty Swallowing
☐ Hoarseness
☐ Swollen Glands
☐ Sleep Apnea
☐ Snoring

Gastrointestinal:
☐ Heartburn
☐ Bloody Stool
☐ Severe Constipation
☐ Severe Diarrhea
☐ Recently Vomited Blood

Skin:
☐ Non-Healing Sores
☐ Changing Mole(s)
☐ Rashes
☐ Unexplained Skin Lesions

Neurologic:
☐ Difficulty Speaking
☐ Dizziness
☐ Numbness/Tingling
☐ Seizures

Y Ears:
☐ Ear Pain
☐ Ear Drainage
☐ Ear Itchiness
☐ Ear Ringing

Respiratory:
☐ Chronic Cough
☐ Coughing Up Blood
☐ Difficulty Breathing
☐ Wheezing
☐ Shortness of Breath

Genitourinary:
☐ Abdominal Pain/Swelling
☐ Blood in Urine
☐ Pain/Burning on Urination

Musculoskeletal:
☐ Chronic Back Pain
☐ Chronic Neck Pain
☐ Trouble Walking

Psychiatric:
☐ Anxiety
☐ Depressed Mood
☐ Substance Abuse
☐ Recent Suicidal Thoughts

SOCIAL HISTORY Government Regulations Require That We Ask:

Do you use tobacco? ☐ Never Smoker ☐ Yes If yes, please answer questions below

☐ Former Smoker When did you quit? _____ When did you start? _____ (year or age)

Do you use alcohol? ☐ No ☐ Yes If you consume alcohol, how often?

☐ 1 time/month ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 times/week

TOBACCO USE

How many cigarettes a day do you smoke?

☐ 5 or less
☐ 6 to 10
☐ 11 to 20
☐ 21 to 30
☐ 31 or more

How soon after you wake up do you smoke your first cigarette?

☐ within 5 minutes
☐ 6 to 30 minutes
☐ 31 to 60 minutes
☐ after 60 minutes

Do you use any tobacco products listed below?

☐ chewing tobacco
☐ pipe

Are you interested in quitting smoking/tobacco use?

☐ ready to quit
☐ thinking about quitting
☐ not ready to quit