The Retreat
Dr Roxana M. Stoici MD

Patient History (1)

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last name: First name: Age: Sex: M F

Doctor's notes (please do not write in this area)

Presenting problem or proposed surgery:

ILLNESS/INJURY: Please check if you have ever had any of the following

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain/tightness			Lung problems/asthma
		History of heart murmur			Shortness of breath
		Stroke			Accidents/broken bones (list)
		Cancer			
		Hepatitis			
		Yellow jaundice			
		Gallstones			

OPERATIONS: List names and dates of all operations you have had

Year	Name of operation	Type of anesthetic, if known	Complications

Have you ever had a blood transfusion? □ Yes □ No If yes, when _____
List any hospital admissions or medical conditions not listed above _____
_____

FEMALES ONLY: Are you pregnant? □ Yes □ No
DRUGS: Please list all drugs you take and their dosages

Drug	Dosage	Drug	Dosage

ALLERGIES: Please list type and reaction

Drug	Reaction	Drug	Reaction

The above information is true and accurate. _____ Patient signature (parent, if patient is a minor) Date				

Ethnic group:

□ Caucasian □ African-American □ Asian
□ Hispanic □ American Indian □ Other _____

Marital status:

□ Single □ Married (how long? _____)
□ Separated □ Divorced (how long? _____) □ Widowed

Children:

Girls _____ Boys _____

Reason for consult at The Retreat?

When did you last feel well (absent of all symptoms)?

_____

Describe the two primary reasons that you are here today:

	Reason 1	**Reason 2**
Explanation		
Date symptoms first occurred		
Frequency of symptoms		
What makes conditions improve?		
What makes conditions worse?		
Do you think this problem will resolve itself?	**□ Yes □ No**	**□ Yes □ No**
Previous treatment		
Practitioner who provided treatment	**Name:** **Phone:**	**Name:** **Phone:**

Who suggested that you seek consult at **The Retreat**?

□ Self □ Referring medical professional □ Family
□ Neighbor/friend □ Advertising

History

Significant birth events:

Premature birth? □ Yes □ No

If yes, how many premature?_____

List all childhood illnesses (continue on reverse if necessary):

Illness *Date(s)*

_____

_____

_____

List all surgeries (continue on reverse if necessary):

Procedure *Date(s)*

_____

_____

_____

List all injuries (continue on reverse if necessary):

Injuries *Date(s)*

_____

_____

_____

Have you been diagnosed with any of the following (currently or in the past)?

__ Heart disease	__ Kidney problems	__ Stroke
__ Seizure disorder	__ Thyroid problems	__ Arthritis
__ High blood pressure	__ Glaucoma	__ Diabetes
__ Obesity	__ High cholesterol	__ Ulcers
__ Periodontal disease	__ Oral gum/bone problem	__ Cancer
__ Whiplash	__ Liver disease	__ Cataracts
__ Depression	__ Manic-depressive disorder	__ Other (list below)

_____

List any other medical conditions you have had (do not include common cold or flu):

Illnesses *Date(s)*

_____

_____

_____

How often do you get a cold? _____

If your family has a history of any of these conditions, please do the following:

a. Circle the condition

b. Write 'F' for father, 'M' for mother, or 'S' for sibling within the parentheses

( ) Heart disease	( ) Kidney problems	( ) Stroke
( ) Cancer	( ) High blood pressure	( ) Diabetes
( ) Obesity	( ) Depression	( ) Schizophrenia
( ) Early senility	( ) Manic-depressive disorder	( ) Other (list below)
( ) Seizure disorder	( ) Alcoholism	

_____

List known allergies (including medication allergies): □ No known allergies

List all prescription and over-the-counter medications you are currently taking. For prescriptions, note the name of the prescribing physician (continue on reverse if necessary):

Prescription medication *Dosage* *Prescribing physician*

List all prescription and over-the-counter medications you have taken in the past. Please note length of use (continue on reverse if necessary):

Prescription medication *Dosage* *Dates*

List all supplements/alternative remedies (vitamins, minerals, herbs, etc.) you are currently taking and/or alternative treatments you are undergoing (continue on reverse if necessary):

Supplement/Alternative treatment *Size (mg, mcg, etc.)* *Daily dose*

List all immunizations you have received:

List any handicaps or impairments (such as vision or hearing loss):

List travel from the past two years (continue on reverse if necessary):

Destination *Date(s)*

Patient History

Name _____ Date of birth _____

Review of systems

Have you ever had any of the following:

Y N		Y N	
	1. Constitutional		**7. Genito-Urinary**
□ □	Recent fever	□ □	Blood in urine
□ □	Recent weight loss	□ □	Painful urination
	2. Eyes		**8. Musculoskeletal**
□ □	Glaucoma	□ □	Frequent fractures or sprains
□ □	Recent changes in vision	□ □	History of arthritis
	3. Ears, Nose, Mouth, Throat		**9. Integumentary**
□ □	Frequent ear infections	□ □	Recent changes in skin
□ □	Frequent sore throats		**10. Neurological**
□ □	Frequent sinus infections	□ □	History of frequent headaches
	4. Cardiovascular	□ □	Seizures or convulsions
□ □	Chest pains or discomfort in chest		**11. Psychiatric**
□ □	Shortness of breath	□ □	Treatment for psychiatric problems
	5. Respiratory (*circle those that apply*)	□ □	Treatment for drug or alcohol dependency
□ □	Asthma, bronchitis, pneumonia, pleurisy, TB		**12. Endocrine**
	6. Gastrointestinal	□ □	Decreased energy
□ □	Frequent indigestion or heartburn	□ □	Dizziness
□ □	Vomiting		**13. Hematologic/Lymphatic**
□ □	Passing bloody or black stools	□ □	Easy bruising or bleeding
			14. Allergic/Immunologic
		□ □	Severe allergic reactions to:
		□ □	Hay fever

Medical problems/hospitalizations:

_____

_____

_____

Surgical procedures:

_____

_____

_____

Medical problems that run in your family (e.g., diabetes, heart problems, cancer)

Medical problem *Family member*

_____

_____

_____

Social history

Y N	
□ □	Do you smoke now?
□ □	Have you smoked in the past? (Year quit:)
□ □	Do you drink alcohol now?
□ □	Did you drink alcohol in the past?

□ □	Do you currently use street drugs?
□ □	Have you used street drugs in the past?
□ □	Are you married?

Signature of person completing the form: □ Patient □ Other _____