Sylvia A. Gisi, M.D.
FAMILY PRACTICE

31493 Rancho Pueblo, Suite 204, Temecula CA 92592
Phone: 951-303-6158 Fax: 951-303-8492

Health History for New Patients

Patient Name: _____ Date: _____

Please list any medical conditions during the past 10 years that required hospitalization or treatment for a period more than 2 weeks.

_____

_____

Have You ever been treated for a traumatic injury? YES ____ NO____

If yes, please specify:

Year: _____ Type of Injury: _____How injury occurred: _____

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FAMILY HISTORY

Please indicate if a family member has been treated for any of the following:

Hypertension	YES ____ NO____
Diabetes	YES ____ NO____
High Cholesterol	YES ____ NO____
Cancer (Type) _____	YES ____ NO____
Stroke	YES ____ NO____
Heart Disease	YES ____ NO____
Depression	YES ____ NO____
Other (Specify) _____	YES ____ NO____

SOCIAL HISTORY

Occupation: _____

Have you traveled outside the US in the past 5 years? YES ____ NO____

Date: _____ Location: _____

Date: _____ Location: _____

LIFESTYLE

Did you or do you smoke? YES ____ NO____

Packs per day _____ For how long _____

When did you quit? _____

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Health History for New Patients

Do you drink alcohol? YES ____ NO____

How often? _____

Have you ever used or are currently using drugs? YES ____ NO____

Explain: _____

MEDICATIONS

Please list all prescriptions/medications you are taking.

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Please list any vitamin/supplements you are taking.

Vitamin/Supplement: _____ Vitamin/Supplement: _____

Vitamin/Supplement: _____ Vitamin/Supplement: _____

Vitamin/Supplement: _____ Vitamin/Supplement: _____

Please list any medication allergies.

Medication: _____ Reaction/Symptom: _____

Medication: _____ Reaction/Symptom: _____

SURGERIES

Please list any surgeries you have had.

Type: _____ Date: _____ Hospital/Facility: _____

Type: _____ Date: _____ Hospital/Facility: _____

MEN ONLY

When was you last PSA? Date: _____

WOMEN ONLY

How many pregnancies have you had? _____ Years: _____

Complications: _____

Have you gone through menopause? YES ____ NO____

Last mammogram: Date: _____ Normal? YES ____ NO____

Last PAP smear: Date: _____ Normal? YES ____ NO____

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Health History for New Patients

REVIEW OF SYMPTOMS

Please describe your general health: Excellent: _____ Good: _____ Fair: _____ Poor: _____

Please check YES or NO to the following health questions, past or present.

Head and Neck

Eye Disease / injury or impairment:	YES ____	NO____
Ear disease / injury or impairment:	YES ____	NO____
Nose sinus, mouth, throat complaints:	YES ____	NO____
Enlarged glands:	YES ____	NO____

Cardiovascular

Chest pain or angina:	YES ____	NO____
Heart murmur:	YES ____	NO____
Heart attack:	YES ____	NO____
Heart surgery:	YES ____	NO____
Heart valve problem:	YES ____	NO____
Heart palpitation or fluttering:	YES ____	NO____
Swelling of ankles feet or hands:	YES ____	NO____
Varicose veins:	YES ____	NO____
High blood pressure (hypertension):	YES ____	NO____
Peripheral vascular disease:	YES ____	NO____

Gastrointestinal

Ulcer or other stomach problems:	YES ____	NO____
Indigestion or pain after eating:	YES ____	NO____
Appendicitis:	YES ____	NO____
Liver disease, hepatitis, or Jaundice:	YES ____	NO____
Gallbladder disease:	YES ____	NO____
Hemorrhoids:	YES ____	NO____
Rectal Bleeding:	YES ____	NO____
Persistent change in bowel habits:	YES ____	NO____

Genitourinary

Bladder or kidney infections:	YES ____	NO____
Blood in urine:	YES ____	NO____
Kidney Stones:	YES ____	NO____
Difficulty urinating:	YES ____	NO____
Incontinence:	YES ____	NO____
Impotence:	YES ____	NO____

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Health History for New Patients

Hematopoietic

Blood Clots:	YES ____	NO____
Easy bruising:	YES ____	NO____
Anemia:	YES ____	NO____
Do you take aspirin?	YES ____	NO____
Dou you take blood thinners?	YES ____	NO____

Metabolic / Endocrine

Diabetes:	YES ____	NO____
Sugar in urine:	YES ____	NO____
Do you take steroids?	YES ____	NO____
Thyroid goiter:	YES ____	NO____

Musculoskeletal

Bane fractures:	YES ____	NO____
Arthritis:	YES ____	NO____

If YES Type: _____

Neurologic

Fainting spells / Loss of consciousness:	YES ____	NO____
Convulsions / Seizures:	YES ____	NO____
Paralysis:	YES ____	NO____
Dizziness:	YES ____	NO____
Frequent and/or severe headaches:	YES ____	NO____

Physiological

Depression:	YES ____	NO____
Anxiety:	YES ____	NO____
Sleep disorders:	YES ____	NO____
Hallucinations:	YES ____	NO____

Respiratory

Chronic or frequent cough:	YES ____	NO____
History of tuberculosis:	YES ____	NO____
Pneumonia:	YES ____	NO____
Emphysema / COPD:	YES ____	NO____
Asthma:	YES ____	NO____

Skin

Skin cancer:	YES ____	NO____
Other skin disorder / disease:	YES ____	NO____