



Name: _____

Clinic #: _____

Date: _____

Patient History Form

Faeza R. Kazmier, M.D.

Name _____ Birthdate _____ Age _____

Height _____ Weight _____

Address _____

Home Phone _____ Work Phone _____

Doctor or person who referred you to see Dr. Kazmier _____

Reason for visit today _____

Prior surgery you've had (include year done): _____

Any medical problems (such as diabetes, heart disease, etc): _____

Current medications (include dose and how many times a day you're taking). Please include herbal supplements (like: Garlic, St. John's Wort, Ginko): _____

Social History: (marital status, occupation): _____

Do you smoke? _____ If yes, how much _____

Do you drink alcohol? _____ If yes, how much _____

Allergies _____

(Continued on back)

Review of Systems

	YES	NO		YES	NO
General:			Genitourinary:		
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	Problems urinating	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting stream/dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Pain, burning, frequency	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal:		
Eyes:			Abnormal growths/lumps	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling/pain	<input type="checkbox"/>	<input type="checkbox"/>
Loss or change of vision	<input type="checkbox"/>	<input type="checkbox"/>	Amputation? What part?	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat:			Skin:		
Hearing aids/hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat/strep throat	<input type="checkbox"/>	<input type="checkbox"/>	Nonhealing, crusting	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Where? _____		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Breasts:		
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Prior biopsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Bloody nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal mammogram	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory:			Neurologic:		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Problems with speech	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric:		
Gastrointestinal:			Prior counseling	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Medication	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Severe depression	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine:		
Vomiting/passing blood	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic:		
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic:		
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>			
HIV infection	<input type="checkbox"/>	<input type="checkbox"/>			