DIMITRY RABKIN, M.D., P.C.

MEDICAL HISTORY

PLEASE PRINT TODAY'S DATE: ____/____/___

PATIENT NAME: _____ _____ _____ DATE OF BIRTH: ___/____/____
LAST *MIDDLE* *FIRST*

NATURE OF THE PROBLEM (CHIEF COMPLAINT) _____

_____

PAST, FAMILY AND SOCIAL HISTORY:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES _____ NO _____

IF YES, PLEASE LIST:

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____

IF YES, PLEASE LIST:

_____

DO YOU OR DID YOU HAVE ANY OF THE FOLLOWING?

Dizziness	YES _____	NO _____	Sinusitis	YES _____	NO _____
Chest Pain	YES _____	NO _____	Hearing Loss	YES _____	NO _____
Heart Attack	YES _____	NO _____	Ear Infections	YE S_____	NO _____
High Blood Pressure	YES _____	NO _____	Pneumonias	YES _____	NO _____
Stroke	YES _____	NO _____	Asthma	YES _____	NO _____
Ulcers	YES _____	NO _____	Bronchitis	YES _____	NO _____
Reflux	YES _____	NO _____	Allergies	YES _____	NO _____
Other Gastrointestinal Problems	YES _____	NO _____	Depression/Anxiety	YES _____	NO _____
Bleeding Disorder	YES _____	NO _____	Arthritis	YES _____	NO _____
Kidney Disease	YES _____	NO _____	Diabetes	YES _____	NO _____
Hepatitis	YES _____	NO _____	Cancer	YES _____	NO _____
			Thyroid	YES _____	NO _____

ARE YOU PREGNANT? YES _____ NO _____
ARE YOU BREAST FEEDING? YES _____ NO _____

PRIOR SURGERIES AND HOSPITALIZATIONS (DESCRIBE):

YEAR	*DESCRIPTION*

DO YOU HAVE A **FAMILY HISTORY** *OF:* *(PLEASE CHECK ALL THAT APPLY)*

□ CANCER	□ STROKE	□ EPILEPSY	□ MENTAL ILLNESS
□ HEART DISEASE	□ HIGH BLOOD PRESSURE	□ BLEEDING DISORDER	□ HEARING LOSS
□ DIABETES	□ ARTHRITIS	□ ASTHMA	□ KIDNEY DISEASE

PLEASE DESCRIBE YOUR HABITS:

□ SMOKE: PACKS DAILY _____ □ ALCOHOL: AMOUNT _____
HOW LONG _____ □ DRUGS: HOW LONG_____

□ SLEEP: □ DIFFICULTY FALLING ASLEEP □ DAYTIME DROWSINESS
□ SNORING □ WAKING UP FREQUENTLY

SIGNATURE OF PATIENT: _____ DR's INITIALS: _____