Lisa Mancuso M.D. – DABPM
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Patient Name: _____ **DOB:**_____

Medical History : _____
(diabetes- insulin or not, heart disease, high blood pressure, acid reflux, asthma, liver disease, kidney disease, cancer, psychiatric, etc.) For more space, please write on back.

Surgical History: _____
(Please include type of surgery and date. For more space, please write on back.)

Drug Allergies? Y / N To What? _____

Latex Allergy? Y / N **Shellfish Allergy**? Y / N **Dye Allergy**? Y / N

If yes, what was the problem? Breathing rash

Family:
Mom (living or deceased, age), health issues

_____

Dad's (living or deceased, age) health issues

_____

Social: marital status M S D **Occupation**:_____

Tobacco? Y / N ____ packs or cans/day Alcohol? Y / N _____drinks/day

Illicit drugs (marijuana or cocaine or other?) Y / N

Review of Systems: (circle items as they apply to you for what you have **now**)

Head: headache, tooth ache

Ears/Eyes/Nose/Throat: blurred vision, hearing loss, vertigo or 'room spins', ear or throat pain

Musculoskeletal: bone pain, muscle pain. muscle loss

Heart: chest pain, palpitations or arrhythmias, edema or limb swelling

Lungs: shortness of breath

GI: jaundice or skin/eyes turn yellow, abdominal pain, constipation

GU: difficulty urinating

Neuro: weakness, numbness or tingling, memory loss, problems with gait or balance

Endocrine: blood sugar too high or too low, significant weight loss or weight gain

Heme: abnormal bleeding

Infectious Disease: Hepatitis B or C , HIV

Psych: "blue" or depressive feelings, nervousness, thoughts of suicide

Patient Signature:

_____ Date:_____