Medical History Questionnaire

Date sent by Office: _______________ Account # _______________
New Patient Appointment Date: __________________ Dr Berkowitz _________________

**Please note: Many of the tests you will have on your first visit will be based on the evaluation of this questionnaire. It is important that we receive it by ____ unless otherwise discussed with the patient representative.*

Name: ____________________________________ Date of Birth:_____________ Sex: M F

Address: __________________________________ Phone: (H)________________ (B): _____________

___________________________________ Weight: __________________ Height: ____________

Health Maintenance Information: In order to provide us with a better understanding of your health needs, please answer all questions as accurately as possible. Approximately when did you last have the following:

Physical Exam	Date:_____________	Gyn	Date: _____________
Electrocardiogram (EKG)	Date:_____________	Mammogram	Date: _____________
Chest X-Ray	Date:_____________	Prostate/Rectal	Date: _____________
Dental	Date:_____________	Colonscopy	Date: _____________
Eye	Date: _____________		

Have you ever been diagnosed with the following:

	YES	NO		YES	NO
Diabetes	______	______	Cancer	______	______
Heart Disease	______	______	Hypertension	______	______

Please discuss your reasons for coming to see Dr. Berkowitz

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	YES	NO	EXPLAIN
1. Are you presently under care of a physician?			
2. Have you ever been hospitalized?			
3. Have you had surgery?			
4. Are you taking medications? Please list.			
5. Have you taken antibiotics?			
6. Are you allergic to any medications?			
7. Do you have food allergies?			
8. Do any specific foods cause you distress?			
9. Do you suffer form chronic fatigue?"			
10. Have you ever had seizures?			
11. Do you smoke? If so, How much?			
12. Have you ever smoked? When did you stop?			
13. Have you ever been told you have sugar in your urine?			
14. Have you ever been told you have diabetes?			
15. Does anyone in your family have diabetes?			
16. Have you ever had high blood pressure?			
17. What is your usual blood pressure?			
18. What is your cholesterol reading?			
19. Does anyone in your family have heart disease?			
20. Have you ever had chest pain?			
21. Have you ever had shortness of breath?			
22. Are you overweight?			
23. Do you feel stressed?			
24. Do you feel depressed, angry with yourself, or feel like you can't keep going under pressure?			
25. Have you ever seen a psychiatrist or been in therapy?			
26. Have you ever had rectal bleeding or black stools?			
27. Have you had any change in bowel or bladder habits?			
28. Has anyone in your family ever had cancer?			