Robert Summerfield, MD
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Personal History

Name _____ Today's Date _____

I. CURRENT PROBLEMS: (Why are you here?)

Date of Onset: _____

II. PAST MEDICAL HISTORY:

Please list all previous surgical operations, please include dates:

Any other significant health problems:

Please list all medications you are now taking.

Are you allergic to any medications?

(Women) Are you pregnant?

III. FAMILY HISTORY:

Have you any family history of:
Neurological Problems -

Heart Disease -

Diabetes -

Other Inherited Conditions -

IV. SOCIAL HISTORY:

Current Employment -

Past exposure to heavy metals, chemical solvents, hazardous or toxic substances:

Do you use alcohol?

Do you smoke?

Are you married?

Do you have children?

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Review of Systems

(Circle # if answer is yes)

Name _____ Today's Date _____

Neurological:

Do you have:

1. Frequent or severe headaches?
2. History of weakness or numbness of arm(s) or leg(s)?

Eye, Ear, Nose and Mouth

Do you have:

3. Serious eye condition?
4. Ear or hearing problems?
5. Problems of the nose, sinuses, mouth or throat?

Heart and Lungs

Do you have:

6. Heart Disease?
7. Undue shortness of breath?
8. Palpitations or "skipped beats"?
9. Chest pain with exertion?
10. Wheezing or asthma?
11. Chronic cough or bronchitis?

Gastrointestinal:

12. Ulcers?
13. Blood in the stool?
14. Chronic diarrhea or constipation?
15. Recurrent abdominal pain?

Genito-Urinary

Do you have:

16. Problems with urinating?
17. Problems with sexual dysfunction?
18. (Women Only) problems with menstrual cycle or post-menopausal bleeding?

Miscellaneous

Do you have:

19. Recurrent join pain or arthritis?
20. Diabetes?
21. Skin problems?
22. Recurrent fevers, chills, night sweats?
23. Recurrent unexplained weight loss?
24. Insomnia or difficulty sleeping?