IRIAMAR VELEZ-QUINONES, MD

PATIENT HISTORY FORM

For office use only:
Record number:_____

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Sex: ❑ F ❑ M Weight:_____ Height:_____

Describe briefly your present symptoms:

Hospitalizations (include where, when, & for what reason):

CURRENT MEDICATIONS

LIST ANY MEDICATIONS/FOOD/SUBSTANCES THAT HAVE CAUSED AN ALLERGIC REACTION:

❑No Known allergy reaction❑ Macrolides ❑Quinolones ❑Codeine ❑Aspirin ❑Acetaminophen ❑ Metals ❑ Penicillin ❑Local anesthetics ❑Iodine ❑Latex ❑Sulfa drugs ❑ Other

_____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

	Name of drug	**Dose (include strength & number of pills per day)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ☐ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Alzheimer
- ❑Parkinson

Other medical conditions (please list):

_____
_____
_____
_____

Family History

Disease	Father	Mother	Paternal Grandparents	Maternal Grandparents	Brother/Sister
Cancer					
Hypertension					
Diabetes					
Mental Disease					
Heart Disease					
Stroke					
Thyroid Disease					

Other:

Tobacco Use:

___Never smoked
___Past Smoker: Quit date_____# Packs/Day_____#Years_____
___Current Smoker: # Packs/Day_____# of Years_____

Alcohol Use:

Do you drink alcohol? No___ Yes____If yes, # of drinks per week:_____
Frequency: Rare_____Social____ Regular Use____ Binges_____

Caffeine Use:

Caffeine Use: No__ Yes____
Type: ___Coffee/___Tea/___Soda # cups per day:_____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
OTHER: specify)_____ _____ _____					Yes ☐ No ☐

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:_____
Pregnancies:_____
Miscarriages:_____
Abortions:_____
Have you reached menopause? ☐ YES / ☐ NO At what age?_____
Do you have regular periods? ☐ YES / ☐ NO
Are you sexually active? ☐ YES ☐ NO

PREVENTION

If over age 30, have you had your cholesterol level checked in the past 5 years? ☐ No ☐ Yes

Have you ever had a mammogram? ☐ No ☐ Yes
If yes, date of last mammogram: _____
Any abnormalities noted? ☐ No ☐ Yes
_____

Have you ever had a colonoscopy? ☐ No ☐ Yes If yes, date of last colonoscopy: _____
Any abnormalities noted? ☐ No ☐ Yes
_____

Have you ever had a bone density or DEXA test? ☐ No ☐ Yes
If yes, date of last screening: _____ Any abnormalities noted? ☐ No ☐ Yes
_____

Date of last dental exam: _____ Date of last eye exam: _____

Immunizations

☐ Tetanus/Yr _____ ☐ Influenza/Yr _____ ☐ Pneumonia/Yr _____ ☐ Shingles/Yr _____

☐ HPV vaccine: #1 _____ #2 _____ #3 _____

☐ Other/Yr _____

Functional status

Do you require any assistance with any of the following?
Bathing _____ Dressing _____ Grooming (brushing hair and teeth, shaving) _____ Toileting, including hygiene afterward _____ Eating, including cutting food _____ Walking, including use of a cane _____ Getting up from a chair or bed _____ Using a telephone _____ Shopping _____ Food Preparation _____ Housekeeping _____ Laundry _____ Transportation _____ Organizing and taking medication _____ Paying Bills _____ Managing Finances _____

PAST SURGICAL HISTORY

SURGERY	DATE	SURGERY	DATE

_____ _____
Patient's signature Date