North Shore LIJ Lenox Hill Hospital

485 Madison Avenue (between. 51st-52nd street)
21st floor
New York, NY 10022

David B. Samadi, M.D.

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PATIENT HISTORY FORM

Date _____

Name _____

Date of Birth _____ Age _____

HISTORY ON PRESENT ILLNESS

What is the main reason for your visit? **(Describe in detail)**

_____

_____

When did you first notice the problem?

_____

Have you seen any doctors for this problem? If so, who have you seen?

_____

_____

PAST MEDICAL HISTORY

Please list any medical problems you have had, and any hospitalizations:

Illness/Hospitalization	**Date**
_____	_____
_____	_____
_____	_____

Please list any surgical procedures you have had:

Surgical Procedures	**Date**
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please list all medications you are currently taking: (including: Aspirin, Vitamins, Supplements, etc)

_____

_____

ALLERGIES

Do you have any allergies to medications? If so, please list below:

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NAME:

SOCIAL HISTORY

Do you smoke? ____Yes ____No If yes, how much? _____

Do you drink alcohol? ____Yes ____No If yes, how much? _____

Do you drink any of the following containing caffeine? If so, how many cups?

Coffee _____ Tea _____ Soda _____

Do you use any drugs? ___Yes ___No If yes, which one(s)

_____

Are you employed? If so, what do you do?

_____

Are you: **(Check one)** ___Married ___Single ___Widowed ___Divorced

How many children do you have? _____ What ages are they? _____

* weight _____
Height _____

FAMILY HISTORY

Do you have any family history of the following?

_____Kidney Stones _____Prostate Cancer _____Testicular Cancer

_____Kidney Cancer _____Bladder Cancer _____Diabetes Other_____

REVIEW OF SYSTEMS

Do you now or have you had any of the following? (Circle Yes or No)

Constitutional Symptoms			**Musculoskeletal**		
Fever	Y	N	Joint Pain	Y	N
Chills	Y	N	Neck Pain	Y	N
Persistent Itch	Y	N	Back Pain	Y	N
Headaches	Y	N	Lower Back Pain	Y	N
Weight Loss	Y	N	Other_____		
Eyes			**Ear/Nose/Throat/Mouth**		
Blurred vision	Y	N	Ear infection	Y	N
Double vision	Y	N	Sore throat	Y	N
Pain	Y	N	Sinus problem	Y	N
Glaucoma	Y	N	Stuffiness	Y	N
Other_____			Change in voice	Y	N
			Decreased hearing	Y	N
Allergic/Immunologic			Hoarseness	Y	N
			Fatigue	Y	N
Hay Fever	Y	N	Loose/Capped teeth	Y	N
Other_____			Other_____		

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NAME:

Neurological		
Tremors	Y	N
Dizzy Spells	Y	N
Numbness	Y	N
Tingling	Y	N
Seizures	Y	N
Weakness	Y	N

Integumentary		
Skin Rash	Y	N
Persistent itch	Y	N
Skin Cancer	Y	N

Other_____

Genitourinary		
Urine Retention	Y	N
Painful Urination	Y	N
Difficult Urination	Y	N
Urinary Frequency	Y	N
Kidney Failure	Y	N
Kidney Stones	Y	N
Sexual Dysfunction	Y	N

Other_____

Respiratory		
Shortness of Breath	Y	N
Asthma	Y	N
Bronchitis	Y	N
Wheezing	Y	N
Frequent coughs	Y	N
Tuberculosis	Y	N
Pain with breathing	Y	N

Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Thyroid Disease	Y	N
Diabetes	Y	N

Other_____

Hematological/Lymphatic		
Swollen glands	Y	N
Blood clotting	Y	N
Low blood counts	Y	N
Blood transfusions	Y	N
Bleeding	Y	N

Other _____

Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Ulcer	Y	N
Food intolerance	Y	N
Jaundice	Y	N
Hepatitis	Y	N

Other_____

Psychologic		
Are you satisfied with your life?	Y	N
Have you considered suicide?	Y	N
Do you hear voices?	Y	N

Other_____

Cardiovascular		
Chest pain	Y	N
Mitral valve prolapse	Y	N
Varicose veins	Y	N
Palpitations	Y	N
Irregular Heart Beat	Y	N
Heart attack	Y	N
Abnormal ECG	Y	N

Physician use only: (Comments/Notes)

☐ **All other ROS Negative**

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____