

Lewis M. Feder M.D.

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **SS#:** _____ **DATE:** _____

Please answer all questions by circling YES or NO. If necessary, write additional information in the "COMMENTS" section.

<p>1. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE A HEART, CIRCULATION OR BLOOD PROBLEM? YES NO</p> <p>A. HEART MURMUR YES NO</p> <p>B. MITRAL VALVE PROLAPSE YES NO</p> <p>C. HEART ATTACK: DATE _____ YES NO</p> <p>D. IRREGULAR HEART BEAT YES NO</p> <p>E. HIGH/LOW BLOOD PRESSURE YES NO</p> <p>F. STROKE OR BLOOD CLOTS YES NO</p> <p>G. ANEMIA/SICKLE CELL YES NO</p> <p>H. ANGINA/CHEST PAIN YES NO</p> <p>I. BLEEDING PROBLEM YES NO</p> <p>J. OTHER HEART PROBLEMS YES NO</p> <p>K. SWOLLEN LEGS/ANKLES YES NO</p> <p>L. SLEEP ON 3 OR MORE PILLOWS YES NO</p> <p>2. DO YOU HAVE OR EVER HAD ANY LUNG OR BREATHING PROBLEMS? YES NO</p> <p>A. ASTHMA YES NO</p> <p>B. BRONCHITIS YES NO</p> <p>C. PNEUMONIA YES NO</p> <p>D. TUBERCULOSIS YES NO</p> <p>E. CHRONIC LUNG DISEASE YES NO</p> <p>F. COUGH FREQUENTLY</p> <p> YES, COUGH UP ANYTHING? YES NO</p> <p>G. DO YOU SMOKE? YES NO</p> <p> HOW MUCH PER DAY? _____</p> <p> # OF YEARS SMOKED? _____</p> <p>H. ABNORMAL CHEST X-RAY YES NO</p> <p>I. SHORTNESS OF BREATH YES NO</p> <p> 1. AT REST YES NO</p> <p> 2. CLIMBING STAIRS YES NO</p> <p> 3. WALKING BRISKLY YES NO</p> <p>3. HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE DIGESTIVE OR STOMACH/LIVER PROBLEMS? YES NO</p> <p>A. DIFFICULTY SWALLOWING YES NO</p> <p>B. HIATAL HERNIA YES NO</p> <p>C. GALL BLADDER DISEASE YES NO</p> <p>D. JAUNDICE (YELLOW SKIN) YES NO</p> <p>E. ULCERS YES NO</p> <p>F. HEPATITIS YES NO</p> <p>G. DIARRHEA/CONSTIPATION YES NO</p> <p>H. WEIGHT LOSS IN LAST 4 MONTHS WITHOUT DIETING YES NO</p> <p>I. EAT ANY SPECIAL DIET YES NO</p> <p>4. HAVE ANY URINARY, KIDNEY OR BLADDER PROBLEMS? YES NO</p> <p>A. KIDNEY STONES YES NO</p>	<p>B. HISTORY OF HEADACHES YES NO</p> <p>C. ARM OR LEG BECOMES WEAK OR NUMB YES NO</p> <p>6. DO YOU HAVE OR EVER HAD:</p> <p>A. DIABETES: IF YES, ARE YOU: DIET CONTROL _____ INSULIN CONTROL _____</p> <p>B. HYPOGLYCEMIC (LOW SUGAR) YES NO</p> <p>C. THYROID PROBLEMS YES NO</p> <p>7. DO YOU HAVE OR EVER HAD:</p> <p>A. PHYSICAL LIMITATIONS OR USE OF AIDES - (WALKER, WHEELCHAIR, ETC.) YES NO</p> <p>B. ARTHRITIS YES NO</p> <p>C. DIFFICULTY WALKING OR LYING FLAT YES NO</p> <p>D. BACK PROBLEMS YES NO</p> <p>E. DIFFICULTY HEARING OR DIFFICULTY SPEAKING YES NO</p> <p>8. ANY MAJOR MEDICAL ILLNESSES? YES NO DESCRIBE _____</p> <p>9. ANY VISION PROBLEMS? YES NO</p> <p>A. GLASSES YES NO</p> <p>B. CONTACT LENSES YES NO</p> <p>10. DENTURES, CHIPPED TEETH, BRACES, BRIDGEWORK, PLATES, LOOSE TEETH (CIRCLE ITEM) YES NO</p> <p>11. ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST/PSYCHOLOGIST? YES NO</p> <p>12. FOR WOMEN ONLY: IS THERE A POSSIBILITY THAT YOU ARE PREGNANT? YES NO</p> <p> DATE OF LAST MENSTRUAL PERIOD _____</p> <p>13. FOR CHILDREN UNDER 16: ARE IMMUNIZATIONS UP TO DATE? YES NO</p> <p>14. HAVE YOU EVER HAD A POSITIVE HIV TEST? YES NO</p> <p> IF YES, IS THE HIV ACTIVE? YES NO</p> <p>15. ADVANCE DIRECTIVE I DO NOT HAVE AN ADVANCE DIRECTIVE.</p> <p> A. I WOULD LIKE INFORMATION ABOUT ADVANCE DIRECTIVES</p> <p> B. I DECLINE INFORMATION ABOUT ADVANCE DIRECTIVES.</p>	<p>LIST ALL MEDICATIONS YOU NOW TAKE, INCLUDING NON-PRESCRIPTION (OVER THE COUNTER) MEDICATIONS:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">MEDICATION DOSE</td> <td style="width: 40%;">HOW OFTEN?</td> </tr> <tr> <td>SUPPLEMENTS</td> <td>_____</td> </tr> <tr> <td>HERBS</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table> <p>LIST ANY ALLERGIES YOU MIGHT HAVE TO MEDICATIONS:</p> <p>_____</p> <p>_____</p> <p>ALLERGIES TO: CONTACT ITEMS (FOOD, TAPE, SOAPS, LATEX)</p> <p>_____</p> <p>_____</p> <p>LIST OPERATIONS/SURGERIES YEAR</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>ANY COMPLICATIONS FROM SURGERY?</p> <p>1. BLEEDING YES NO</p> <p>2. INFECTION YES NO</p> <p>3. THICK SCAR YES NO</p> <p>4. SLOW TO HEAL YES NO</p> <p>5. OTHER _____</p> <p><u>ANESTHESIA HISTORY</u></p> <p>HAVE YOU OR A BLOOD RELATIVE EVER HAD A PROBLEM WITH GENERAL OR LOCAL ANESTHESIA? YES NO</p> <p>NAUSEA OR VOMITING YES NO</p> <p>DROP/INCREASED BLOOD PRESSURE YES NO</p> <p>DIFFICULTY IN "WAKING UP" YES NO</p> <p>INCREASED TEMPERATURE YES NO</p> <p>DIFFICULTY BREATHING YES NO</p> <p>PLEASE COMPLETE THE FOLLOWING QUESTIONS</p> <p>1. NAME OF FAMILY PHYSICIAN _____ LOCATION _____</p> <p>2. DO YOU CONSUME ALCOHOL YES NO</p> <p> HOW MUCH PER DAY _____</p> <p style="text-align: right;">YES NO</p>	MEDICATION DOSE	HOW OFTEN?	SUPPLEMENTS	_____	HERBS	_____	_____	_____	_____	_____	_____	_____
MEDICATION DOSE	HOW OFTEN?													
SUPPLEMENTS	_____													
HERBS	_____													
_____	_____													
_____	_____													
_____	_____													

I HAVE AN ADVANCE
DIRECTIVE ON FILE
HISTORY OF CANCER? YES NO

C. DIFFICULT OR PAINFUL — IF SO, WHERE?

IF YES, SITE: _____

DATE _____

URINATION YES NO

D. UNABLE TO HOLD URINE YES NO

COMMENTS: _____

4. FAMILY HISTORY OF CANCER YES NO

5. DO YOU HAVE OR EVER HAD ANY
OF THE FOLLOWING:

IF YES, SITE:
RELATIONSHIP

A. SEIZURE OR CONVULSION YES NO

My signature to the right certifies that this information is correct to the best of my knowledge.

Lewis M. Feder, M.D.

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LESION HISTORY OF _____

Patient's Name date of birth

HAVE YOU RECENTLY NOTED LESIONS? _____

HAVE YOU HAD A RECENT ONSET OF LESIONS? _____

HAVE YOU NOTED LESIONS GROWING IN SIZE? _____

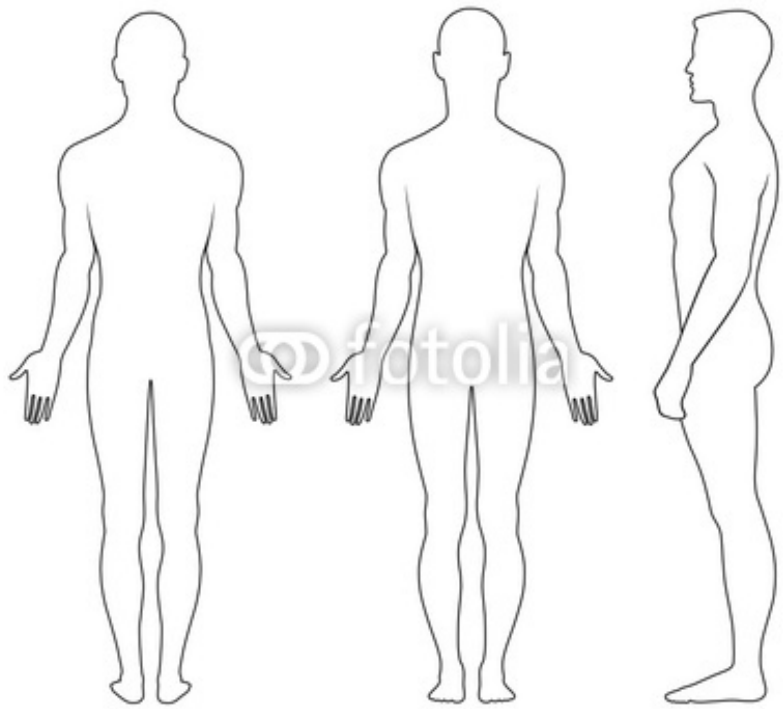
ARE YOU CONCERNED ABOUT CANCER? _____

IS THERE FAMILY HISTORY OF CANCER? _____

5. WOULD YOU DESCRIBE YOURSELF
AS EXTREMELY ANXIOUS IF
CONSIDERING SURGERY? YES NO

PATIENT SIGNATURE

STAFF SIGNATURE



Location of lesions? _____

Is there pain from lesions? _____

Patient signature _____

date _____