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In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

- | | | | | | |
|--|------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Murmur | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer – where? | | <input type="checkbox"/> Pass Out | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hemorrhoids |
| _____ | | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Surgeries _____ | | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Allergies _____ | |
| _____ | | _____ | | _____ | |
| _____ | | _____ | | _____ | |

FAMILY MEDICAL HISTORY:

Mother: Age: _____ Living Deceased

Please check each box if your mother has (had) the following problems:

- | | | | | | |
|--|------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Murmur | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer – where? | | <input type="checkbox"/> Pass Out | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hemorrhoids |
| _____ | | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Surgeries _____ | | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Allergies _____ | |
| _____ | | _____ | | _____ | |
| _____ | | _____ | | _____ | |

Father: Age: _____ Living Deceased

Please check each box if your father has (had) the following problems:

- | | | | | | |
|--|------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Murmur | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer – where? | | <input type="checkbox"/> Pass Out | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hemorrhoids |
| _____ | | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Surgeries _____ | | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Allergies _____ | |
| _____ | | _____ | | _____ | |
| _____ | | _____ | | _____ | |

Siblings: Age: _____ () Living () Deceased

Please check each box if your siblings has (had) the following problems:

- | | | | | | |
|--|---|--|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Murmur | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer – where? | <input type="checkbox"/> Pass Out | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hemorrhoids | |
| _____ | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma | |
| _____ | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Allergies _____ | | |
| <input type="checkbox"/> Surgeries _____ | | | | | |
| _____ | | | | | |
| | | | | | |

SOCIAL HISTORY:

Check all boxes that pertain.

- Marital Status () Married () Divorced () Single () Widowed () Separated
- Living () At home () Alone () Senior Citizen () Nursing Home () With Family
- Occupation(s) () _____ () _____ () _____
- Exposure to: () Dusts () Fumes () Asbestos () Chemicals
() Other

Sexual History: () Sexual Active () Not sexually active

CURRENT MEDICATIONS:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

- | | | | |
|----------------------------------|---|----------------------------------|-----------------------|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Type: _____ | <input type="checkbox"/> Alcohol | Type: _____ |
| | <input type="checkbox"/> Year begun: _____ | | How often: _____ |
| | <input type="checkbox"/> Still smoking | | How much: _____ |
| | <input type="checkbox"/> Year quit: _____ | | How many years: _____ |
| | <input type="checkbox"/> Packs per day: _____ | | |

Other: _____

REVIEW OF SYSTEMS:

SYSTEM	QUESTIONS Do you have the following?:	NO	YES	COMMENTS
Constitutional	Weight gain			
	Weight loss			
	Fever			
	Hair loss			
	Weakness			
	Other:			
Eyes	Eye strain			
	Wear glasses or contact lenses			
	Sensitivity to light			
Ear, Nose, Mouth, Throat	Ringing in ears			
	Hearing loss			
	Discharge or pain			
	Dizziness			
	Runny nose			
	Difficulty breathing through nose			
	Sinusitis			
	Painful teeth, gums, or palate			
	Growths in the mouth			
	Pain or difficulty swallowing			
	Hoarseness			
Cardiovascular	Palpitations			
	Awaken at night short of breath			
	Passing out spells			
	Shortness of breath with exertion			
	Dizziness			
	Shortness of breath while lying flat			
	Difficulty climbing stairs			
	Varicose veins			
	Other:			
Respiratory	Shortness of breath while walking			
	Cough with or without phlegm			
	Asthma/Wheezing			
	Spit up blood			
	Other:			
Gastrointestinal	Pain in stomach before, during or after eating			
	Nausea			
	Vomiting			
SYSTEM	QUESTIONS Do you have the following?:	NO	YES	COMMENTS
Gastrointestinal Cont'd	Change in shape or color of stool			
	Diarrhea			
	Hemorrhoids			
Genitourinary	Discharge			
	Frequent urination			

	Pain with urination			
Musculoskeletal	Weakness			
	Pain in back, neck, legs, or arms			
	Other:			
Skin	Jaundice			
	Moles that have changed color, shape, or bleed			
	Growths on sun exposed areas			
	Other:			
Neurologic	Tremor			
	Weakness in extremity			
	Other:			