

Patient History Form

Internal Medicine/ Richard Gobao M.D., LLC

Do you have a history of ...? (Please mark all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Chronic Heartburn |
| <input type="checkbox"/> Tension Headache | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Urine Infections |
| <input type="checkbox"/> Periperal Neuropathy | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Prostate Enlargemnt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Allergies (dust,pollen) | <input type="checkbox"/> Edema | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Emphysema (COPD) | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Diabetes Mellitus | _____ |
| | <input type="checkbox"/> Insulin | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Oral Medication | _____ |

Past Surgical and Procedure History (check those that apply)

- | | |
|---|---|
| <input type="checkbox"/> Appendectomy (Year_____) | <input type="checkbox"/> Stress Test (Year/Hospital)_____ |
| <input type="checkbox"/> Cholecystectomy (Year_____) | <input type="checkbox"/> Colonoscopy (Year_____) |
| <input type="checkbox"/> Heart By-Pass Surgery (Year _____) | <input type="checkbox"/> Endoscopy (Year_____) |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> CAT Scan (Year/Hospital)_____ |
| <input type="checkbox"/> Right Eye (Year_____) | <input type="checkbox"/> Brain <input type="checkbox"/> Chest |
| <input type="checkbox"/> Left Eye (Year_____) | <input type="checkbox"/> Spine <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Bowel Resection (Year_____) | <input type="checkbox"/> MRI (Year/Hospital)_____ |
| <input type="checkbox"/> Hernia Surgery (Year _____) | <input type="checkbox"/> Brain <input type="checkbox"/> Spine |
| <input type="checkbox"/> Hip Replacement (Year_____) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Knee Replacement(Year_____) | |

Have your been hospitalized in the last 3 years? If yes, please list the details:

Date:_____ Hospital:_____ Reason:_____

Date:_____ Hospital:_____ Reason:_____

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