

Name: _____

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"/> Peripheral Neuropathy | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Prostate Enlargement |
| <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 Apnea | <input type="checkbox"/> Diabetes Mellitus | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Insulin | _____ |
| | <input type="checkbox"/> Oral Medication | _____ |

Past Surgical History

- | | |
|---|---|
| <input type="checkbox"/> Appendectomy (Year _____) | <input type="checkbox"/> Gall Bladder Surgery (Year _____) |
| <input type="checkbox"/> Heart By-Pass Surgery (Year _____) | <input type="checkbox"/> Cardiac Catheterization/stent (Year _____) |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Right Eye (Year _____) | <input type="checkbox"/> Right/Left Hip (Year _____) |
| <input type="checkbox"/> Left Eye (Year _____) | <input type="checkbox"/> Right/Left Knee (Year _____) |
| <input type="checkbox"/> Bowel Resection (Year _____) | <input type="checkbox"/> Other _____ |

Male Patients

When was your last: Prostate Exam _____ Colonoscopy _____

Female Patients

When was your last: Pap Test _____ Mammogram _____ Colonoscopy _____

Please list any Hospitalizations in the Last 3 years

1. _____
2. _____
3. _____
4. _____