ROBERT J. SPIES, M.D. PC HEALTH HISTORY FORM

PLEASE	E PRINT					
NAME:				DATE:		
PAST OF	PERATION	IS:				
				late, age at the time of the operation, and the name on sillectomy, hemorroidectomy, etc.}.)		
DATE:	AGE:	OPERATIONS:	S: PHYSICIAN/FACILITY			
ACCIDE	MTC.			I		
List any	serious ty		h the approximate date, you fracture or trauma, serious I	r age, type of injury, and the name of the physician acerations, etc.}		
DATE:	AGE:	TYPE OF INJU		PHYSICIAN/FACILITY		
	LNESSES:					
AGE:		ILLNESS:				
ALLERG	SIES:					
NO KNO	WN ALLEF	RGIES:	_			
Please ch	eck any me	edications(s) which	you are allergic to:			
AspirinCodeineDemerolTetracyclineTylenolErythromycinIbuprofenMorphine			Marcaine Lidocaine Sulfa Percodan Percocet Penicillin Valium Vicodin			
011			vicodili			
	edication (s	. ,				
ARE YO	U ALLERG	SIC TO:				
	Adhe	esive Tape	lodine	Latex		

MEDICATIONS YOU ARE PRESENTLY TAKING:

Do you smoke cigarettes? NO YES how many packs a day: Do you use any form of nicotine substances? (Vape, Gum, Patches, chew tobacco) NO YES, how often Do you use any form of Marijuana? (smoke/ vape, edibles) NO YES, type and frequency Do you drink any alcohol? NO YES, how many per week FAMILY HISTORY: If ANY of the following run in your family please check and specify which family member. Pulmonary Embolus Heart Disease Strokes Cancer Strokes Diabetes Anesthesia Reactions HEALTH SCREENING: Adverse effect to any anesthetic (If so please specify) Angina Asthma Easy Bruising Tendency Blood Clots in Legs Frequent Pneumonia Prolonged Bleeding Heart Attack Diabetes Recurrent Infections Pacemaker (cardiac) Hepatitis Thyroid Issues: Low or High (circle) Pulmonary Embolism Jaundice (skin turns yellow) Stroke High Blood Pressure Heart Rhythm Disturbances Congestive Heart Failure Bronchitis Cancer REVIEW OF SYSTEMS: Please check the appropriate squares in the following list of symptoms. (If you are having or have had the symptoms in the last six months). HEAD & NECK SYMPTOMS Severe Headaches Severe Hearing Loss Toothache at present Dizzy Spells Ringing in Ears Chronic Sore Tongue Persistent Sore Gums Persistent Sore Gums Persistent Neck Rigidity See "Floating Lights" Pain in Ears Swelling in Neck HEART & LUNG SYMPTOMS Chest Pain on Effort Sit up to breath easily Skipping Heart Beats Chronic Cough Ankles Swollen	MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBED BY
FOR WOMEN ONLY) Do you take Estrogens (creams, shots, pills) or birth control pills?				
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Please specify: SOCIAL HISTORY: Do you smoke cigarettes? NO YES how many packs a day: Do you use any form of nicotine substances? (Vape, Gum, Patches, chew tobacco) NO YES, how often Do you use any form of Marijuana? (smoke/ vape, edibles) NO YES, type and frequency Do you drink any alcohol? NO YES, how many per week FAMILY HISTORY: If ANY of the following run in your family please check and specify which family member. Pulmonary Embolus Heart Disease Cancer Strokes Diabetes Anesthesia Reactions HEALTH SCREENING: Adverse effect to any anesthetic (If so please specify) Angina Asthma Easy Bruising Tendency Prolonged Bleeding Heart Attack Diabetes Recurrent Infections Pacemaker (cardiac) Hepatitis Repatitis Thyroid Issues: Low or High (circle) Pulmonary Embolism Jaundice (skin turns yellow) Stroke High Blood Pressure Congestive Heart Failure Bronchitis Cancer REVIEW OF SYSTEMS: Please check the appropriate squares in the following list of symptoms. (If you are having on have had the symptoms in the last six months). HEAD & NECK SYMPTOMS Severe Headaches Severe Hearing Loss Torothache at present Dizzy Spells Ringing in Ears Chronic Sore Tongue Failing Vision Discharge from Ears Persistent Sore Gums Pyer Pain Repeated Nose Obstructions Persistent Neck Rigidity See "Floating Lights" Pain in Ears Chronic Nose Obstructions Persistent Neck Rigidity See "Floating Lights" Pain in Ears Skipping Heart Beats Chronic Cough Ankles Swollen	HEIGHT:	WEIGHT:	BMI:	
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Angina	HEALTH SCREENING:			
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Skipping Heart Beats Chronic Cough Ankles Swollen			eacily Nial	at eweste
	Difficulty breathing	Spit up Blood		

STOMACH & INTESTINAL SYMP	PTOMS	
Chronic Abdominal Pain	Vomit Blood	Clay Colored Stools
Persistent Nausea	Chronic Diarrhea	Habitual Constipation
——Heartburn	Black Tarry Stools	Hemorrhoids
Appetite Loss	Blood from rectum	Recurrent Vomiting
URINARY & MENSTRUAL SYMP	PTOMS	(for women and s)
Evene Ulimetian	Dain with University	(for women only)
Excess Urination	Pain with Urination	Excess Menstruation
Urinary Shutdown	Leakage of Urine	Painful Menstruation
Scanty Urination	Passed any stones	Bleed between periods
Blood in Urine	Bedwetting	Missed periods
Excessive night urination	Retention of Urine	Pelvic infections
NERVE MUSCLE & JOINT SYMP	TOMS	
Numbness	Shaking	Speech Disturbances
Disturbance in walking	Joint Trouble	Seizures
Tingling Sensations	Nervous Breakdown	Drug Problems
Muscle jerking	Unusual Stress	Alcohol Problems
Paralysis	Memory Loss	Mental Problems
Recurrent Muscle Cramps	Personality Changes	Mental Problems Blackout Spells
Are there any additional health	factors in your history which h	ave not been covered in this medical history
form?(If yes, please use	e the following space for addition	onal comments.)
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