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

PLEASE PRINT

NAME: _____DATE: _____

PAST OPERATIONS:

NONE_____. (Or list any past operations with the approximate date, age at the time of the operation, and the name of the physician and facility. {Include minor operations such as tonsillectomy, hemorroidectomy, etc.}.)

DATE:	AGE:	OPERATIONS:	PHYSICIAN/FACILITY

ACCIDENTS:
List any serious type of injuries with the approximate date, your age, type of injury, and the name of the physician and hospital. {Include burns, nasal fracture or trauma, serious lacerations, etc.}

DATE:	AGE:	TYPE OF INJURY:	PHYSICIAN/FACILITY

PAST ILLNESSES:

AGE:	ILLNESS:

ALLERGIES:

NO KNOWN ALLERGIES: _____
Please check any medications(s) which you are allergic to:

____Aspirin
____Codeine
____Demerol
____Tetracycline
____Tylenol
____Erythromycin
____Ibuprofen
____Morphine
____Marcaine
____Lidocaine
____Sulfa
____Percodan
____Percocet
____Penicillin
____Valium
____Vicodin

Other medication (specify)_____

ARE YOU ALLERGIC TO:

____Adhesive Tape ____Iodine ____Latex

MEDICATIONS YOU ARE PRESENTLY TAKING:

MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBED BY

HEIGHT:_____ WEIGHT:_____ BMI: _____

(FOR WOMEN ONLY) Do you take Estrogens (creams, shots, pills) or birth control pills? _____
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
____Blood Clots in Legs
____Heart Attack
____Pacemaker (cardiac)
____Pulmonary Embolism
____Stroke
____Congestive Heart Failure
____Cancer
____Asthma
____Frequent Pneumonia
____Diabetes
____Hepatitis
____Jaundice (skin turns yellow)
____High Blood Pressure
____Bronchitis
____Easy Bruising Tendency
____Prolonged Bleeding
____Recurrent Infections
____Thyroid Issues: Low or High (circle)
____Blood Disorder
____Heart Rhythm Disturbances

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
____Dizzy Spells
____Failing Vision
____Eye Pain
____Double Vision
____See “Floating Lights”
____Severe Hearing Loss
____Ringing in Ears
____Discharge from Ears
____Repeated Nosebleeds
____Chronic Nose Obstructions
____Pain in Ears
____Toothache at present
____Chronic Sore Tongue
____Persistent Sore Gums
____Prolonged Hoarseness
____Persistent Neck Rigidity
____Swelling in Neck

HEART & LUNG SYMPTOMS

____Chest Pain on Effort
____Skipping Heart Beats
____Difficulty breathing
____Sit up to breath easily
____Chronic Cough
____Spit up Blood
____ Night sweats
____Ankles Swollen
____Any Heart Defects

STOMACH & INTESTINAL SYMPTOMS

____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 SYMPTOMS

		(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 SYMPTOMS

____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	____Blackout Spells

Are there any additional health factors in your history which have not been covered in this medical history form?_____(If yes, please use the following space for additional comments.)

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