Jon M. Grazer, MD, MPH, Inc.
400 Newport Center Drive, Suite 302, Newport Beach, CA 92660
949-644-1240

Health History

(Confidential)

Name _____Today's date_____
Age _____Birthdate _____Date of last physical exam_____
Reason for your visit?_____

Please circle symptoms you currently have or have had in the past year:

General:
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness sweats

Muscle/Joint/Bone:
Pain, weakness, numbness in:
Arms, hips, back, legs, feet
Neck, hands, shoulders

Genito-Urinary:
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

Gastrointestinal:
Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea-Gas
Excessive hunger
Excessive thirst
Hemorrhoids
Indigestion
Vomiting
Rectal bleeding
Nausea
Vomiting
Vomiting blood

Cardiovascular:
Chest pain
High/Low blood pressure
Irregular/Rapid heart beat
Poor circulation
Swollen ankles/Varicose veins

Eye, Ear, Nose, Throat:
Bleeding gums
Blurred vision/Double vision
Crossed eyes
Difficulty swallowing
Earache/Ear discharge
Hay fever/Nosebleeds
Hearing loss/Ringing in ears
Persistant cough
Sinus problems
Vision flashes/Vision halos

Skin:
Bruise easily/Hives
Itching/Mole changes
Rash/Scars
Sore that won't heal

Please circle CONDITIONS you have or have had in the past:

AIDS / Alcoholism / Anemia / Anorexia / Appendicitis / Arthritis / Asthma / Bleeding Disorders / Breast Lump / Bronchitis / Bulimia / Cancer / Cataracts / Chemical Dependency / Chicken Pox / Diabetes / Emphysema / Epilepsy / Glaucoma / Goiter / Gonorrhea / Gout / Heart Disease / Hepatitis / Hernia / Herpes / High Cholesterol / HIV Positive / Kidney Disease / Measles / Migraine Headaches / Miscarriage / Mononucleosis / Multiple Sclerosis / Mumps / Pacemaker / Pneumonia / Polio / Prostate Problem / Psychiatric Care / Rheumatic Fever / Stroke / Suicide Attempt / Thyroid Problems / Tonsillitis / Tuberculosis / Typhoid Fever / Ulcers / Vaginal Infections / Venereal Disease

List ALL MEDICATIONS you are currently taking: **Medication/substance ALLERGIES:**

_____ _____
_____ _____

Have you ever taken Fen-Phen? Yes / No

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Health History (cont)

Please fill in information about your **Family history:**

	Age	State of Health	Age at Death	Cause of Death
Father:				
Mother:			Age of Death	
Brothers:			Age of Death	
			Age of Death	
Sisters:			Age of Death	
			Age of Death	

Please circle any of the following diseases your blood relative have or have had:
Arthritis / Gout / Asthma / Hay Fever / Cancer / Chemical Dependency / Diabetes /
Heart Disease / Strokes / High blood Pressure / Kidney disease / Tuberculosis /
other_____

Hospitalizations:

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes / No

Please list serious injuries or illness with the dates and outcome:

Please list all Pregnancies, including dates and complications if any:

Circle which substance you use and describe how much:
Caffeine_____ Drugs_____
Tobacco_____ Other_____

_____ _____
Patient Signature Date

Reviewed By _____ Date _____

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Insurance Patients

Please be advised that our office is not contracted with any insurance company. We will accept PPO plans however you will be charged for services up front. The PPO will be billed promptly in the effort to reimburse you only up to the amount you paid us.

I understand the above paragraph:

Patient Signature _____ Date _____

Witness _____ Date _____