RICHARD T. DAUPHINÉ, MD
PATIENT HEALTH HISTORY

NAME:____DATE:______________________

MEDICATION ALLERGIES:____

Name and City of Your Family Doctor;____

Head and Face History

Do you now or have you ever had:
Prolonged (migraine type) Headaches   Dizziness   Loss of Consciousness   Stroke
Other Head or Facial Problem____

Eye History

Do you now or have you ever had:
Blurred Vision   Vision Loss   Glaucoma   Other Eye Problem_____________

Ear, Nose, Throat, Mouth, and Neck History

Do you now or have you ever had:
Hearing Loss   Repeated Ear Infections   Repeated Bloody Nose   Gum Disease
Persistent Sore Throat   Frequent Cold Sores   Other Ear, Nose, Throat, Mouth, or Neck Problem
Explain:____

Breathing History

Do you now, or have you ever had:
Asthma   Bronchitis   Emphysema   Other Respiratory Condition______________

Do you smoke?   No   Yes   Quantity________________

Are you exposed to hazardous substances at home or work? No   Yes Explain_______________

Cardiac and Vascular History

Have you ever had:
Heart Attack   Irregulat Heartbeat
Do you now or have you ever had:
Heart Disease   Ankle Swelling   High Blood Pressure   Decreased Blood Circulation
Blood Transfusion(s)   Other Heart or Blood Vessel Problems_____________________

(Women) Breast Exam History

Do you perform:
Monthly Self Breast Exams   Yes   No   If no, why not?_____________________________
If over 40, do you have regularly scheduled mammograms?   Yes   No If no, why not?_________
Do you have any relatives who have had breast cancer? Yes   No
Do you need a referral to a care provider for breast exam instruction? Yes   No

---

Abdominal History

Do you sometimes pass blood in your stool for unknown reasons? Yes   No
Do you generally have periods when you are unable to have a bowel movement? Yes   No
Do you have any history of Hepatitis? Yes   No Other Abdominal Problems? Yes   No
Explain:____

Hormonal Genitourinary History

Do you have diabetes? Yes No If Yes, do you or have you taken insulin? Yes No

Have you had more than one bladder infection this year? Yes No
Blood in your urine? Yes No
Difficulty controlling your bladder? (Pass urine when laughing or when unintended?) Yes No

WOMEN:
If over 40, and in or approaching menopause, are you on hormone replacement? Yes No
Do you take calcium supplements? Yes No
If over 40, have you evver had a bone density test? Yes No
Would you like a referral for any of these issues? Yes No

MEN:
Diffilcuty starting to urinate or in continuing until your bladder is empty? Yes No
If over 40, have you had a prostate exam in the last year? Yes No
If over 50, have you had a prostate blood test in the last 2 years? Yes No
Would you like a referral for any of these issues? Yes No

Medication History

Is there a medication which you have taken, are not allergic to, but had other types of problems with it?
Yes No If yes, please list medications and what happened:______________________________________

____

Please list any medications you are taking, including the dose strength, and date started: None

____

____

Please list the date(s) of cortisone injections you have had over the last year: None

____

Surgical History

Please list Surgeon's name, Date, Type of Surgery, if you have had any surgeries: None

____

____

____

Have you ever had a reaction to local or general anesthesia? No Yes, Explain:________________________

____

Any other surgical complications?: No Yes, Explain:____

____

Social History

Do you drink alcohol? No Yes If yes, how often and how much?____________________________
Do you or have you had a drug addiction or dependence problem? No Yes , Explain:________

____

Do you or have you used "recreational" or non-prescription drugs? No Yes, Explain___________________

____

Other Information

Please list any other information you wish to discuss:____

____

____

____