GHD GUSTAVO H. DAY M.D. INTERNAL MEDICINE

Self Pay or Commercial Insurance

GUSTAVO H. DAY. M.D., P.A.

MEDICAL HISTORY

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

FAMILY HISTORY

Father: ☐ Living ☐ Deceased (Cause): _____

Mother ☐ Living ☐ Deceased (Cause): _____

Siblings: Number Living _____ Number Deceased _____ (Cause) _____

Check illnesses which have occurred in any of your blood relatives:

☐ Cancer ☐ Asthma ☐ Jaundice ☐ Diabetes ☐ Anemia ☐ Bleeding Tendency ☐ Kidney Disease
☐ Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Depression ☐ Anxiety ☐ Allergies
☐ Other: _____

PAST MEDICAL HISTORY

Current Immunizations Received:

☐ Small Pox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Hepatitis A ☐ Hepatitis B ☐ Pneumonia

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: _____

Have you ever had a blood Transfusion? ☐ Yes ☐ No Date: _____

Which of the following conditions are you currently being trated or have been treated for in the past

☐ Diabetes ☐ Glaucoma ☐ Heart Problems ☐ Vein Problems ☐ Cancer ☐ Seizures ☐ Stroke
☐ Asthma ☐ High blood pressure ☐ Jaundice ☐ Depression/Anxiety ☐ Arthritis ☐ Kidney Problems
☐ Allergies ☐ Bleeding Tendencies ☐ Tuberculosis ☐ Headaches / Migraines ☐ Heartburn (reflux)
☐ Other: _____

Please list your past surgeries: _____

_____

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No List: _____

Current Medications: _____

_____

*Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many packs per day? _____

* Do you drink alcohol, beer or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks per week? _____

* Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day? _____

Last Menstrual Cycle: _____ Cycles are: ☐ Regular ☐ Irregular

Oral Contrceptives: ☐ Yes ☐ No Number of Pregnancies: _____ Number of Miscarriages: _____

Dressed Weight: _____ How long have you been this weight? _____

What is the reason for visit today? _____

_____