Martha L. Zambrano, MD

Health History
(Confidential)

Name _____ Today's Date _____

Age _____ Birth Date _____ Date of Last Physical Examination _____

What is the reason for your visit? _____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING	

ALLERGIES

SYMPTOMS (Check (√) symptoms you currently have or have had in the past year)

GENERAL	**GASTROINTESTINAL**	**EYE, EAR, NOSE, THROAT**	**MEN only**
Chills	Appetite	Bleeding Gums	Breast Lump
Depression	Bloating	Blurred Vision	Erection Difficulties
Dizziness	Bowel Changes	Crossed Eyes	Lump in Testicles
Fainting	Constipation	Difficulty Swallowing	Penis Discharge
Fever	Diarrhea	Double Vision	Sore on Penis
Forgetfulness	Excessive Hunger	Earache	Other
Headache	Excessive Thirst	Ear Discharge	**WOMEN only**
Loss of Sleep	Gas	Hay Fever	Abnormal Pap Smear
Loss of Weight	Hemorrhoids	Hoarseness	Bleeding Between Periods
Nervousness	Indigestion	Loss of Hearing	Breast Lump
Numbness	Nausea	Nosebleeds	Extreme Menstrual Pain
Sweats	Rectal Bleeding	Persistent Cough	Hot Flashes
MUSCLE/JOINT/BONE	Stomach Pain	Ringing in Ears	Nipple Discharge
Pain, Weakness, Numbness in:	Vomiting	Sinus Problems	Painful Intercourse
Arms Hips	Vomiting Blood	Vision - Flashes	Vaginal Discharge
Back Legs	**CARDIO VASCULAR**	Vision - Halos	Date of last menstrual period:
Feet Neck	Chest Pain	**SKIN**	
Hands Shoulders	High Blood Pressure	Bruise Easily	Date of last Pap Smear:
GENITO-URINARY	Irregular Heart Beat	Hives	
Blood in Urine	Low Blood Pressure	Itching	Have you had a mammogram?
Frequent Urination	Poor Circulation	Change in Moles	
Lack of Bladder Control	Rapid Heart Beat	Rash	Are you pregnant?
Pain Urination	Swelling of Ankles	Scars	
	Varicose Veins	Sore Throat That Won't Heal	Number of children:

CONDITIONS (Check (√) symptoms you currently have or have had in the past year)

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

PALM BEACH NEUROSCIENCE INSTITUTE

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(All information is strictly confidential)

FAMILY HISTORY (Fill in health information about your family)

Relation	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√) if blood relatives has any of the following:	Disease	Relationship to you
	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

Pregnancy History

Year of Birth	Sex of Birth	Complication if any

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

If yes, please give approximate dates:

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS (Check (√) which substances you use and how much you use)

Caffeine	
Tobacco	
Drugs	
Other	

OCCUPATIONAL CONCERNS

(Check (√) if your work exposes you to the following:

Stress	
Hazardous Substances	
Heavy Lifting	
Other	

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

Martha L. Zambrano, MD

Signature **Date**