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Date _____

PATIENT MEDICAL HISTORY

NAME: _____ SS#: _____

DATE OF BIRTH: _____ BIRTHPLACE: _____

SOCIAL:

Marital Status: _____ Spouse's Name: _____

Work Status: Full time Part time Retired Not working

Employer: _____

Student: Full time Part time None

HEALTH HABITS:

Do you smoke? _____ Did you ever smoke? _____

of cigarettes a day _____ For how many years? _____

Caffeine intake: Coffee _____ Tea _____ Cola _____ Cups a Day: _____

Do you drink alcohol? _____

Have you ever.....	Yes	No	
Felt the need to cut down on drinking alcohol?	_____	_____	
Felt annoyed by criticism of your drinking	_____	_____	
Had guilty feelings about drinking?	_____	_____	
Taken a morning eye opener?	_____	_____	
Do you exercise regularly?	_____	_____	
How would you describe your health?	Good	Fair	Poor

REVIEW OF PROBLEMS:

(circle what is bothering you):

- General: Wt loss Wt gain Loss of appetite Fatigue
- Weakness Depression High blood pressure
- Sleep: Insomnia Sleepiness
- Head: Headache Memory problems Dizziness
- Eyes: Vision change Eye pain
- Ears: Earaches Hard wax Trouble hearing
- Nose: Congestion Nosebleeds Sinus problems
- Throat: Trouble swallowing Swelling or goiter
- Lungs: Cough Wheezing Shortness of breath
- Heart: Chest pain/pressure Irregular heartbeats
- Breasts: Lump Discharge Tenderness
- Abdomen: Heartburn Abdominal pain Constipation
- Diarrhea Change in stools Blood in stools
- Kidney/Bladder: Blood in urine Pain Burning Loss of control
- Females: Vaginal discharge Irregular bleeding
- Males: Discharge Hernia Impotence
- Joint/Muscle: Pain Stiffness Deformity
- Which joints: _____
- Gland: Diabetes Thyroid trouble
- Other (not listed) _____

HEADACHES:

Frequency: _____
Location: _____
Time of the day or night: _____
Duration: _____

HEALTH PREVENTION: (Write in year last done)

Tetanus _____ Flu shot _____ Pneumonia vaccine _____
TB test _____ Eye exam _____ Sigmoidoscopy _____
Rectal exam _____ PAP smear _____ Mammogram _____
Chest x-ray _____ EKG _____ Cholesterol _____

PAST MEDICAL HISTORY: (List operations, injuries and illnesses)

Problem	Year	Physician or Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS:

NAME	DOSAGE (MGS)	HOW MANY TIMES A DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:

Are you allergic to any drugs or medications? _____
Any side effects to any drugs? _____
Name of drug and describe reaction: _____

FAMILY HISTORY:

Has any family member had (circle all that apply)

Diabetes Heart attack Breast cancer Stroke
Colon cancer Seizure (epilepsy) High blood pressure

Put in age or age of death and health for each family member:

Father _____ Mother _____
Brother _____ Sister _____
Brother _____ Sister _____
Brother _____ Sister _____
Child _____ Child _____
Child _____ Child _____
Child _____ Child _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

(Someone who does not live with you)

Name: _____
Relationship: _____
Phone: _____
Address: _____

