Patient Medical History Form

Name: _____ Birth Date: _____ Today's Date: _____

Please list your main concern for today's visit:
_____
_____

How long have you experienced this problem?
_____

What other treatments have you tried for this problem?_____
_____

Who is your primary doctor?_____

How did you hear about our clinic? (doctor, friend, internet, etc)_____

Do you have medication allergies? YES NO
If yes, please list:_____
_____

Do you take medications, including nasal sprays, herbal medication and over-the-counter medications? YES NO If yes, please list:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list your prior surgeries: _____

_____ _____
_____ _____
_____ _____

Please list the medical problems you are treated for:_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you use tobacco? YES NO

Have you used tobacco in the past? YES NO
If yes, Quit Date: _____ Years of use: _____

Do you drink alcohol? YES NO
If yes, average # of drinks per week: _____

Do you use any illicit drugs? YES NO
If yes, please describe_____

Who lives in your household? _____
_____

What is your current occupation? _____
_____

Please list any medical problems that run in your family: _____
_____

Has anyone in your family had difficulty with anesthesia, easy bleeding or bruising? YES NO

For women, are you pregnant or could you be pregnant? YES NO

Preferred pharmacy: _____

Have you had any of the following? YES NO If yes, please check or circle

Frequent/recent headaches	Liver disease or hepatitis	Urinary tract infections
Migraines	Breathing difficulty	Difficulty urinating
Weakness in arms or legs	Coughing up blood	Kidney stones
Numbness	Pneumonia	Prostate enlargement
Stroke or aneurysm	Tuberculosis	Unusual vaginal bleeding
Changes in eyesight	Syphilis	Night Sweats
Fainting spells/dizziness	Ankle swelling	Blood in the urine
Glaucoma or cataracts	Stomach problems	High blood pressure
Eye surgery	Ulcers	Diabetes
Ringing in the ears	Indigestion or heartburn	Thyroid problems
Heart problems	Rectal bleeding/dark stools	Fevers/Chills
Angina or chest pain	Constipation or diarrhea	Weight loss
Heart rhythm problems	Gallstones	Depression
Heart failure	Gallbladder surgery	Easy bleeding/bruising
Heart surgery	New or changing moles	Problems at birth
Arthitis or joint pain	Recent skin changes	Cancer/Leukemia

REBECCA GOLGERT, M.D.
2420 Castillo St., Suite 100, Santa Barbara, CA 93105
Tel (805) 563-1999 Fax (805) 563-4999