Smriti Goel M.D., S.C.

PATIENT SELF HISTORY

Patient Name: _____Date of birth: _____

Reason for your visit today _____

Have you ever been in the hospital or had surgery? If yes, for what and when?

_____

_____

Please check all past or present medical problems and/or symptoms:

Anemia		Heart Disease		Any other Bleeding	
Arthritis		Chest Pain		Easy Bruisability	
Asthma		High blood Pressure		Abnormal Vaginal Discharge	
Cancer		Kidney Disease		Abnormal Penile Discharge	
Diabetes		Prostate Disease		Psychiatric Problems	
Fibroids		Urinary Incontinence		Seizures	
Gout		Difficulty Urinating		Stroke	
Alcoholism		Liver Disease		Thyroid Disease	
Glaucoma		Lung Disease		# of Pregnancies	
Hearing Loss		Shortness of breath		HIV	
Visual Loss		Ulcers		Sexually transmitted Disease	
Heart Attack		Gastrointestinal Bleeding		Drug Substance Abuse	

Please list medications you are currently taking (please use additional sheet if needed):

_____

_____

Please list all allergies and the reaction:

_____

_____

FAMILY MEDICAL HISTORY:

Relation	**Age**	**Disease**	**Disease if deceased, Cause and age of death**

707 Lake Cook Road, Suite 260, Deerfield IL 60015. Tel (847)564-0055, Fax (847)564-0051

SOCIAL HISTORY:

Do you smoke? If yes, how much and how often?

_____

Do you drink alcohol? If yes, how much and how often?

_____

Do you use illicit drugs? If yes, what kind and how often?

_____

Is there any exposure to dust, fumes, smoke, or noise?

_____

Are you watching you diet or following any strict dietary guidelines?

_____

Do you exercise regularly?

_____

Do you take any non-prescription medications, health foods, or vitamins?

_____

Health Screening/Immunizations	**Date & Results**
Pap smear	
Mammogram	
Chest X-ray	
Physical Examination	
Digital Rectal Examination	
Prostate Examination/PSA	
Stool Hemocculs	
Flexible Sigmoidoscopy	
Colonoscopy	
Cholesterol	
Blood Sugar	
PPD	
Influenza Vaccine	
Tetanus/TDAP	
Hepatitis B Vaccine	
Chicken Pox or Vaccine	

Patient Signature_____Date_____

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