

Neil Baum, M.D.

3525 Prytania Street
Suite 614
New Orleans, LA 70115
Ph: (504)891-8454 Fax: (504)891-8505

NOTE: This is a confidential record and will be kept at your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

DATE _____/_____/_____
LAST NAME _____ FIRST NAME _____ MIDDLE _____
SOCIAL SECURITY NO. _____ DATE OF BIRTH _____/_____/_____
REF. PHYSICIAN _____ PRIMARY PHYSICIAN _____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail.)

For Physician's Use Only (4)

History Of Present Illness

*Location _____
*Quality _____
*Severity _____
*Duration _____
*Timing _____
*Context _____
*Motivating Factors _____
*Associated Signs & Symptoms _____

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, cancer, heart disease, etc.)

List any personal past illnesses and/or surgeries and when they occurred.

| Illness or Surgery | Date | Illness or Surgery | Date |
|---------------------------|-------------|---------------------------|-------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Are you on any medications? YES OR NO

Do you: Consume caffeinated food/drinks? YES OR NO Smoke? YES OR NO
If yes how much? _____ If yes how long/packs per day? _____

Consume Alcohol? YES OR NO Have a special diet? _____
If yes how much? _____

Do you have any known drug allergies? YES OR NO (If yes, list all.) _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle yes or No.

A. Constitutional Systems

Fever Y N
Chills Y N
Headache Y N
Other _____

B. Eyes

Blurred Vision Y N
Double Vision Y N
Other _____

C. Allergic/Immunologic

Hay Fever Y N
Drug Allergies Y N
Other _____

D. Neurological

Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other _____

E. Endocrine

Excessive Thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other _____

F. Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Other _____

G. Cardiovascular

Heart Trouble Y N
High Blood Pressure Y N
Other _____

H. Integumentary

Skin Rash Y N
Other _____

I. Musculoskeletal

Joint Pain Y N
Back Pain Y N
Other _____

J. Ear/Nose/Throat/Mouth

Sinus Problems Y N
Other _____

K. Genitourinary-Male

Urine Retention Y N
Erectile Dysfunction Y N
Urinary Frequency Y N
Other _____

L. Genitourinary-Female

Loss of Urine Y N
Painful Urination Y N
Urinary Frequency Y N
Date Last Menstrual Period:
Other _____

M. Respiratory

Frequent Cough Y N
Shortness of Breath Y N
Other _____

N. Hematological/Lymphatic

Swollen Glands Y N
Blood Clotting Problems Y N
Other _____

O. Psychologic

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Other _____

Physician: _____

Date: ____/____/____