

**ANDREW CHERTOFF, M.D.**

**MEDICAL HISTORY**

(If answer is NONE to any questions, please state so)

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PRIMARY CARE/REFERRING PHYSICIAN: \_\_\_\_\_

New problem Yes \_\_\_ No \_\_\_, if yes, please give area of the body. \_\_\_\_\_

Date of onset of new problem \_\_\_\_\_ How injury occurred \_\_\_\_\_

Please list **Any Allergies** to medication and their reactions: \_\_\_\_\_

ANY LATEX ALLERGIES \_\_\_ Yes \_\_\_ No

**PLEASE CHECK IF ANY OF THESE APPLY TO YOU**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Other Heart Disease       | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Transfusions          | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Varicose Veins        | <input type="checkbox"/> HIV/AIDS                  | <input type="checkbox"/> Leg ulcers          |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Bowel problems        | <input type="checkbox"/> Stomach ulcers            | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Trouble with Anesthesia | <input type="checkbox"/> Stroke/CVA Date _____ | <input type="checkbox"/> Trouble Walking Distances |  |
| <input type="checkbox"/> Number of Pregnancies   | <input type="checkbox"/> How many births       | Please explain _____                               |  |

Please list any present/past medical problems that we should be aware to in addition to the above. \_\_\_\_\_

Please list any surgical procedures and date of procedures: \_\_\_\_\_

Please list all current medications including dose and number per day. \_\_\_\_\_

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

**SOCIAL HISTORY**

Have you ever smoked? Yes \_\_\_ No \_\_\_

Do you currently smoke? Yes \_\_\_ No \_\_\_

How long have you smoked? \_\_\_\_\_

How much do you smoke? \_\_\_\_\_

If you quit smoking, how long ago? \_\_\_\_\_

How much did you smoke? \_\_\_\_\_

Alcohol History: Daily: Yes \_\_\_ No \_\_\_

Weekly: Yes \_\_\_ No \_\_\_

Socially: \_\_\_\_\_

Never: \_\_\_\_\_

**FAMILY HISTORY**

Cancer     Diabetes     Heart Disease     Bleeding Problems     Vascular Problems

SIGNATURE (Patient/Parent/Guardian) Please Circle    DATE

PHYSICIAN'S SIGNATURE    DATE