New Jersey Vision Associates, P.C. **Patient Health History**
Mitchell Vogel, M.D., F.A.C.S.

Review of Systems-Check any current symptoms you have:

CONSTITUTIONAL
_____ Recent fevers/sweats/chills
_____ Unexplained weight loss/gain
_____ Unexplained fatigue/weakness

EARS/NOSE/THROAT
_____ Hearing loss / ringing in ears
_____ Earache / ear discharge
_____ Trouble swallowing
_____ Sore throat
_____ Nasal congestion / allergies

EYES
_____ Vision loss / blurred vision
_____ Pain / burning
_____ Tearing / redness / itching
_____ Dryness

CARDIOVASCULAR
_____Chest pains/discomfort
_____Palpitations
_____Shortness of breath
_____High blood pressure

RESPIRATORY
_____ Cough/wheeze
_____Coughing up blood
_____Shortness of breath

GASTROINTESTINAL
_____Heartburn/reflux
_____Nausea/vomiting
_____Diarrhea / constipation
_____Pain in abdomen
_____ Change/blood in bowel move.

GENITOURINARY
_____Painful/bloody urination
_____Lack of bladder control
_____Nighttime urination

MUSCULOSKELETAL
_____Muscle/joint pain / aches
_____Recent back pain
_____Arthritis
_____Muscle weakness
_____Joint deformities

SKIN
_____Rash / itching
_____New or change in mole
_____ Growth/warts

NEUROLOGICAL
_____Headaches
_____Memory loss
_____Dizziness / fainting

PSYCHIATRIC
_____Anxiety/stress
_____Sleep problems
_____Depression

BLOOD/LYMPHAT/IMMUNO
_____Easy bruising/bleeding
_____ Anemia
_____Unexplained lumps

ENDOCRINE
_____Diabetes
_____Increased thirst/appetite
_____Thyroid problems

FEMALES: Are you pregnant/nursing? Y N

ALLERGIES: (Meds/foods/substances)____

MEDICATIONS: List meds you are currently taking with dosages and frequencies: _____________________
____
____

PERSONAL MEDICAL HISTORY: have you had any of the following medical problems?
_____Heart disease
_____Asthma/lung disease
_____Cancer
______High blood pressure
______Diabetes
______Stroke
______High cholesterol
______Thyroid problems
______Kidney disease

Cancer type: ________________________ Other: ____

SURGICAL/HOSPITAL HISTORY: Please list all prior operations/hospitalizations:

____

FAMILY HISTORY: Please indicate family members with any of the following conditions:
Alcoholism__________________________
High blood pressure__________________
Heart disease________________________
Diabetes___________________________
Depression_____________________
Asthma______________________
Stroke_______________________
Glaucoma____________________
High cholesterol___________
Cancer___________________
Thyroid disease____________
Kidney disease_____________

Other heritable disease:____

SOCIAL HISTORY:
Do you drink alcohol? Yes No If so, how much? _____________________
Do you smoke? Yes No If so, how much? _____________________
Do you use any recreation drugs? Yes No Caffeine intake: None Coffee/tea/soda ____cups/day
Main reason for today's visit with Dr. Vogel: ____
Patient Name: _________________________________ Date of Birth: ________________________________
Patient Signature________________________________ Today's Date:_________________________________
Reviewed by: __________________________________ **Mitchell Vogel, M.D, F.A.C.S.**