MEDICAL HISTORY PAGE 1

Michael Cheikin MD

Last Name	First Name:	Today's Date

Date of Birth:	Age	Height	Weight	Dominance: R L

How did you learn about our practice?	**LEAVE BLANK**
Please describe the problem(s) that brought you here:	
(☐ more on back)	
When did THIS episode begin?	
How did THIS episode begin?	
If recurrent or intermittent, when did the FIRST episode begin?	
What is your theory (or "internet diagnosis") of how this developed (even if strange or rejected by others)	
What are your main goal(s) in seeking our services?	
1)	
2)	
3)	
In what time frame do you wish to achieve your main goal(s)?	
What percentage improvement in your problem(s) will satisfy you?	

PAST MEDICAL HISTORY

		LEAVE BLANK
Do you have allergy to LATEX?	No Yes	
... to any MEDICATIONS? (if yes, please list on back)	No Yes	
... to any ENVIRONMENTAL AGENTS (such as pollen, if yes please list)	No Yes	
Have you seen any OTHER PRACTITIONERS in the last 5 years? (if yes, list on Medical Survey)	No Yes	
Have you had any INPATIENT SURGERY? (if yes, please note on Medical Record Survey)	No Yes	
Have you had any OUTPATIENT SURGERY? (if yes, please note on Medical Record Survey)	No Yes	
Have you had any HOSPITALIZATION(S)? (if yes, please note on Medical Record Survey)	No Yes	
Have you had any ER VISITS in the last 5 years (if yes, please note on Medical Record Survey)	No Yes	
Have you had any URGENT CARE CENTER VISITS in the last 2 years	No Yes	

Please list the MOST RECENT TESTS:	**Date**	**Reason**	LEAVE BLANK
Blood Tests in the past year			
XRay			
CAT Scan			
Colonscopy/Endoscopy			
Dexascan (Bone Density Test)			
EKG			
EMG			
Mammogram/Prostate Exam			
MRI			
Stress Test			
Other:			