MATTHEW L. FINERMAN, M.D., INC.
Century City Medical Plaza ~ 2080 Century Park East, Suite 1703, Los Angeles, CA 90067 ~ (310)201-0990 Fax (310)201-9665

PATIENT'S NAME:_____ **DATE OF VISIT**: ____/____/____
DATE OF BIRTH: _____/_____/_____ **OCCUPATION** _____

REASON FOR VISIT: _____

CURRENT MEDICINES/DOSES: 1. _____ **ALLERGIES TO MEDICINES:**

2. _____ 5. _____ 1. _____
3. _____ 6. _____ 2. _____
4. _____ 7. _____

PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (with years)

Illnesses/Injuries1. _____ 2. _____ 3. _____

Hospitalizations1. _____ 2. _____ 3. _____

Operations 1. _____ 2. _____ 3. _____

FAMILY HISTORY (please check) ___Heart Disease ___Diabetes ___ Cancer ___ Other _____

Which family member?_____

Do you drink soda/coffee/tea? __ No, *never* __ No, *but I used to* __ Yes ~ Cups/Drinks per day? _____
Do you drink alcohol? __ No, *never* __ No, *but I used to* __ Yes ~ How many drinks? _____/day or wk?
Do you smoke? __ No, *never* __ No, *but I used to* __ Yes ~ Packs per day? _____x_____ years
Do you use illicit drugs? __ No, *never* __ No, *but I used to* __ Yes ~ Which? _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)

CONSTITUTIONAL
weight gain/loss(>15lbs) Y N
constant night sweats Y N

EYES
double vision Y N
glaucoma Y N

EAR/NOSE/THROAT
hearing loss Y N
ear pain Y N
ringing in ears Y N
balance problems Y N
hearing aid Y N
difficulty breathing Y N
nosebleeds Y N
nasal drainage Y N
sinus problems Y N
snoring Y N
voice changes Y N

CARDIOVASCULAR
heart attack Y N
high blood pressure Y N
heart murmur Y N

GASTROINTESTINAL
diarrhea Y N
heartburn Y N

ENDOCRINE
diabetes Y N
thyroid disease Y N
autoimmune disease Y N

NEUROLOGIC
headaches Y N
seizures Y N
stroke Y N

HEMATOLOGY
bruise easily Y N
anemia Y N
cancer Y N

GENITOURINARY
frequent urination Y N
prostate problems n/a Y N

SKIN
past skin cancer Y N
past radiation therapy Y N

MUSCULOSKELETAL
arthritis Y N
back pain Y N

RESPIRATORY
asthma/emphysema Y N
chronic cough Y N
Tuberculosis Y N

PSYCHIATRIC
anxiety Y N
depression Y N
sleep problems Y N

OTHER _____

If YES to any of the above, please explain:_____

_____

Reviewed by: _____ M.D.