Haydee Docasar, M.D.

www.haydeedocasarmd.com

NEW MALE PATIENT HISTORY

I. Identifying Information

Name: _____ DOB: _____ Date: _____

Reason for visit_____

Age: _____ Marital Status: _____ Occupation: _____

Who referred you? _____

Name of internist or family doctor: _____

Spouse/Partner's name: _____Occupation: _____

List any other physicians or health care providers you see and Specialty:

_____

II. Medical History ☐ None

Please list any medical problems that you have.

_____

_____

_____

Have you had any hospitalization, injuries, fractures or motor vehicle accidents? ☐ None

_____

_____

Check if you have or have you ever had:

☐ Alcohol abuse	☐ Anesthetic reaction	☐ Bleeding disorder
☐ Asthma	☐ Anemia	☐ Chronic lung condition
☐ Blood clots	☐ Drug and substance abuse	☐ Depression/anxiety
☐ Diabetes	☐ Heart disease	☐ High blood pressure
☐ High cholesterol	☐ Hepatitis/Jaundice	☐ Cancer (Type)
☐ Irritable bowel syndrome	☐ Kidney stones	☐ Hypothyroidism
☐ Seizure disorder	☐ Stroke	☐ Tuberculosis
☐ Stomach ulcers	☐ Mitral valve prolapse	☐ Rheumatic fever
☐ Transfusion reaction	☐ Eating disorder	☐ Lupus/autoimmune disorder

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List all medications that you take with the dose and timing: ☐ None

Drug	Dose	Frequency	Reason for medication

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: ☐ None

_____

_____

Allergies: List all adverse reactions or allergies you have to medications and what happened. ☐ None

_____

_____

_____

III. Surgical History ☐ None

List all surgeries you have had including biopsies.

Date	Operation	Diagnosis

IV. General Health

How much alcohol do you drink/week? ☐ None ☐ Avg. less than 1/day ☐ Avg. 1/day ☐Avg. more ____

Do you smoke? ☐ Yes ☐ No Amount/day _____ How many years_____

If you quit smoking, when did you stop? _____

Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type: _____

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