**SIDNEY J. STEINBERGER, M.D., F.A.C.S.**
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(Please complete both sides of this form and circle **Yes or No** where appropriate)

## *PATIENT MEDICAL HISTORY:

Name of Patient:_____ Exam Date:_____

Date of Birth:_____ Age:_____ Height:____ft.___in. Weight:_____pounds Collar Size_____

***Medication Allergies:** **Yes / No** If **Yes,** please list and describe reaction:_____

_____

*LIST ALL PRESCRIBED MEDICATIONS YOU ARE TAKING OR ATTACH A LIST:

| Medication | Dose and Frequency | Reason for Taking |
|---|---|---|
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| | | |

Do you take Aspirin, Herbal medications Vitamins, other over the counter medications, or Street Drugs?
**Yes/ No,** If **Yes,** Please list: _____

## *SOCIAL HISTORY

Occupation/Employer: _____ No. of Years:_____

Do you smoke? **Yes / No** If **Yes,** How many packs per day?_____ How many Years?_____

Have you ever smoked regularly? **Yes / No** If **Yes,** No. of pks./day:_____ No. of Years:_____

When did you quit? _____

Do you consume alcohol? **Yes / No** If **Yes,** amount/day:_____ How often?_____ Type:_____

Have you ever been a heavy consumer of alcohol? **Yes / No** If yes, How much/long_____

## *SURGICAL HISTORY:

Have you had any surgery? **Yes / No** If **Yes,** please list:

| Approximate Year | Type of Surgery | Reason |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

**Who is you primary care/family physician?**_____

Physician's address:_____

Did he or she refer you? **Yes / No**

If **Not,** how were you referred? Friend/Relative_____ Health Plan Book_____ Yellow Pages_____

Other_____

Office Use Only

M.D. Review/Date ___/___ ___/___ ___/___ ___/___ ___/___