

# LESLIE SHAWN, D.O.

## INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.  
It will help your physician to know not only about your health but also about your family and relatives.

TODAY'S DATE

NAME	ADDRESS
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TELEPHONE NUMBER	DATE OF BIRTH	AGE	PLACE OF BIRTH	RACE OR NATIONALITY OF PARENTS
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RELIGION	EDUCATION (Highest level attained)	OCCUPATION ▶	HOW LONG
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PRESENT MARRIAGE (Year married)	PREVIOUS MARRIAGE (Year married and duration)
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WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

ALIVE ▶ DECEASED ▶	FATHER <input type="checkbox"/> <input type="checkbox"/>	Present health or cause of death	MOTHER <input type="checkbox"/> <input type="checkbox"/>	Present health or cause of death	SPOUSE <input type="checkbox"/> <input type="checkbox"/>	Present health or cause of death
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BROTHERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
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SISTERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
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CHILDREN ▶	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH
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CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Diabetes     Cancer     Bleeding tendency     Kidney disease  
 Tuberculosis     Heart disease     Stroke     High blood pressure     Nervous illness     Allergy     Other

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD

Diabetes     Glaucoma     Heart trouble     Syphilis     Vein trouble  
 Cancer     Asthma     Jaundice     Gonorrhoea     Bleeding tendencies     Tuberculosis     Pneumonia     Kidney disease  
 Rheumatic fever     Nervous disorder     Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?

No     Yes ▶ LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

NO     Yes ▶ LIST:

DO YOU USE TOBACCO NOW?	IN THE PAST?	TYPE AND DAILY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		

DO YOU USE ALCOHOLIC BEVERAGES?	TYPE	WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			

DO YOU DRINK COFFEE?	WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶		

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

Smallpox     Tetanus     Typhoid     Polio     Influenza     Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES
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HAVE YOU TAKEN CORTISONE-TYPE DRUGS?	ORAL CONTRACEPTIVES?	HAVE YOU RECEIVED A BLOOD TRANSFUSION?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes ▶    DATE:

DRESSED WEIGHT	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?
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WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician)	DATE
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