DEAN A. KOCAY, M.D.

Last Name		Referring Physician	
First Name		Family Physician	
Initial		Other Physicians	
Date of Birth		Current weight	Current height

Describe the reason for your visit, please be specific and include information such as location, duration, presentation, when symptoms began, etc...:

MEDICATIONS

MEDICATIONS (Please list all of the medications you are taking; include over the counter, supplements, herbs, etc..) Please indicate the dosages (i.e. milligrams, micrograms, teaspoons, etc.) along with the frequency and prescribing physician.

List all allergies to medicines, latex, adhesives, etc.

Have you had a Tetanus shot in the last 10 years?	☐ Yes	☐ No
Have you ever had any adverse reactions to anesthesia?	☐ Yes	☐ No
Do you have any bleeding tendency or clotting disorder?	☐ Yes	☐ No

List any surgical procedures you have had (please include year, place of service, and doctor):

List any hospitalizations (please include year, place of service, and doctor):

FAMILY HISTORY

Has anyone in your family ever had cancer, heart disease, diabetes, or any other medical illnesses?

Breast	☐ Yes	☐ No
Ovarian	☐ Yes	☐ No
Colon	☐ Yes	☐ No
Pancreatic	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Others	☐ Yes	☐ No

If yes, please explain (include who, their age of diagnosis and treatment if known)

SOCIAL HISTORY

Do you use tobacco products?	☐ Yes	☐ No	How much?
Do you drink alcoholic beverages?	☐ Yes	☐ No	How much?
Do you drink caffeinated coffee, tea, soda?	☐ Yes	☐ No	How much?
Do you use illicit drugs? (cocaine, marijuana)	☐ Yes	☐ No	How much?

PAST MEDICAL HISTORY

Condition:

Stroke	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
Thyroid cancer	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No	Blood clots	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lymphedema	☐ Yes	☐ No
HIV infection	☐ Yes	☐ No	Stomach ulcer	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Depression, anxiety, etc.	☐ Yes	☐ No
Tuberculosis (t.b.)	☐ Yes	☐ No	Angina	☐ Yes	☐ No
Reflux esophagitis	☐ Yes	☐ No	Swelling/ Edema	☐ Yes	☐ No

Remarks

REVIEW OF SYSTEMS

Headaches	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No
Double/blurred vision	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Corrected vision	☐ Yes	☐ No	Productive cough	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Abnormal menstruation	☐ Yes	☐ No
Hard of hearing	☐ Yes	☐ No	Leg ulcers	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No	Leg cramps	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No	Loss of appetite	☐ Yes	☐ No

Remarks

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Heartburn	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Bloating	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No
Dark or bloody stool	☐ Yes	☐ No	Back pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Difficulty urinating	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Kidney stones	☐ Yes	☐ No
Change in bowels	☐ Yes	☐ No	Blood transfusion	☐ Yes	☐ No
Colon polyps	☐ Yes	☐ No	Radiation exposure	☐ Yes	☐ No

Remarks

Have you ever had a colonoscopy? If YES, when and where? What were the findings?

Have you ever had a mammogram? If YES, when and where? What were the findings?

Do you have any other circumstances or problems the doctor should know about?

Emergency contact

Phone Number

Pharmacy/Location

Phone Number

Signature

Current Date

Submit by Email

Print Form