**Alina Rabinovich, M.D**

**133 East 58th Street, Suite 401**

**New York, NY 10022**

**HISTORY QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hm Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Can we text you about Promotions and other office information?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the **chief complaints** that brought you to our office today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please **LIST ALL MEDICATIONS** you are currently taking. This should include patches, eye drops, aspirin, birth control pills and non- prescription drugs such as vitamins or herbs. (**Attach a separate list if necessary or bring complete list with you to your appointment)**

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| MEDICATION | DOSE/FREQUENCY | MO/YRS TAKEN | REASON PRESCRIBED |
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**ALLERGIES TO MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PAST MEDICAL HISTORY (Please CIRCLE):**

Anxiety/Depression Asthma Atrial Fibrillation Aneurysm Autoimmune Disorder

Alcohol/Drug Abuse Brain Tumor Cancer Dementia Diabetes Head Injury/Trauma

Heart Attack Heart Disease Hepatitis HIV High Cholesterol High Blood Pressure Lupus

Liver disease Lyme Meningitis Migraine Multiple Sclerosis Myasthenia Gravis

Parkinson’s Disease Peripheral Neuropathy Peripheral Vascular Disease Polycystic Kidney Disease

Renal Disease Rheumatoid Arthritis Seizures Stroke Thyroid disease

Please explain above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY MEDICAL HISTORY:** (**Please indicate** **by circling** if any immediate family members have any of the illnesses below)

Coronary Artery Disease (<55y/o) Stroke ( < 55 y/o ) Peripheral Neuropathy Peripheral Vascular Disease

Tremors/ Involuntary Movements Anxiety / Depression Other Psychiatric Illness Diabetes

Alzheimer's disease Other Dementia Muscular Dystrophy Kidney Disease Parkinson’s Disease

High Cholesterol High blood pressure (Hypertension) Cancer Migraines Other Headaches

Heart Attack Multiple Sclerosis Lupus Rheumatoid Arthritis Seizures

Please explain above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SOCIAL HISTORY: Smoking/Tobacco Use:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS: ( Please circle if you have had any of the following in the past 6 months )**

**GENERAL:**  Fever Fatigue Weight Loss Chills Sweats Lack of appetite

**NEURO:** Headaches Imbalance Slurred Speech Numbness/Tingling Muscle weakness Seizures

Dizziness Memory Changes Difficulty Sleeping Excessive Sleepiness During Day Tremors

**EYES:** Burry Vision Double Vision Dry Eyes Pain Eye Lid Droop

**ENT:** Congestion Facial Pain/Pressure Hearing Loss Ringing in Ear(s)

**MUSCULOSKELETAL:** Back pain Neck pain Joint pain Joint swelling Muscle cramps

Muscle Twitching Jaw Pain/Tension

**PSYCH:** Anxiety Depression Excessive eating/shopping Hallucinations

**SKIN:** Easy Bruising Rash Itching

**RESPIRATORY:** Cough Shortness of Breath

**GENITO-URINARY:** Urinary Frequency Urinary Urgency Incontinence

**GASTRO-INTESTINAL:** Constipation Diarrhea Nausea Changes in Stool

**CARDIOVASCULAR:** Chest Pain Palpitations Fainting

**ENDOCRINE:** Cold/Heat Intolerance Weight Changes

**HEMATOLOGY:**  Abnormal bruising Bleeding

**MISCARRIAGES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (PRINTED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_