**VINCENT C. HUNG, M.D., F.A.C.S.**

PLEASE COMPLETE THE FOLLOWING GENERAL MEDICAL HISTORY FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific problems for today's appointment** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you consulted any other Doctors, including Surgeons, about this? ☐Yes ☐No

If yes, please list their names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of doctors - please mark none if none-**

 **General:**\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ophthalmologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radiologist/Oncologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SYSTEMS REVIEW - CHECK ALL THAT APPLY REGARDING YOUR HEALTH AND ADD OTHER IMPORTANT PROBLEMS**

**Medications**: Allergic to any medications? ☐none ☐yes list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On any medication now? ☐none ☐yes list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On any blood thinners? ☐none ☐yes last taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Are you taking any Aspirin or Aspirin-like products (e.g. Aleve, Bufferin, and Motrin) ☐no ☐yes last taken: \_\_\_\_\_\_***

**Infections** **Hematologic/lymphatic** **Constitutional Symptom** **Eyes/Ears/Nose/Throat**

☐none ☐normal ☐none ☐normal

☐HIV/AIDS ☐anemia ☐weight loss/weight gain ☐glaucoma

☐hepatitis ☐bleeding problems ☐fever ☐hearing aid

☐tuberculosis (T.B.) ☐enlarged lymph nodes ☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐plastic surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_

☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular** **Respiratory** **Gastrointestinal** **Musculoskeletal**

☐normal ☐normal ☐normal ☐normal

☐angina ☐asthma ☐stomach ulcer ☐arthritis

☐artificial limb ☐emphysema ☐colitis ☐artificial joint

☐pacemaker ☐COPD ☐other GI problems: ☐other:

☐hypertension ☐other lung problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐mitral valve prolapse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological** **Psychiatric** **Endocrine** **Skin**

☐normal ☐normal ☐normal ☐abnormal scarring

☐stroke ☐depression ☐diabetes ☐poor healing

☐seizures ☐anxiety attacks ☐thyroid ☐other skin disorders

☐other: \_\_\_\_\_\_\_\_\_ ☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY**: **Major illness or hospitalizations**: ☐ none List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take antibiotics prior to dental or other procedures**? ☐Yes ☐ no if yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

 **Has any relative had**: ☐tuberculosis ☐Cancer ☐Diabetes ☐Epilepsy ☐Heart Disease

 ☐Asthma ☐High Blood Pressure ☐Lung Disease ☐Kidney Disease

 ☐Blood/Bleeding Disorders ☐Mental Disease

 **Relative Age State of Health**

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Brother(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sister(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you - Wear**: ☐ dentures ☐glasses ☐ contact lenses **Smoke**: ☐yes packs per day \_\_ ☐no ☐former smoker **Drink alcohol**: ☐no ☐social/occasional drinking only ☐ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol or drug problems/addictions**: ☐none ☐yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_