SAMUEL BUNDZ, M.D., P.A.

MEDICAL HISTORY

Do Not Fill In The Boxed Areas

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Marital Status: _____

FOR DOCTORS USE ONLY

Chief Complaint: _____

History of Present Illness: _____

_____

_____

_____

_____

Personal Medical History:

History Of:	Yes	No	Where	When		Yes	No	Where	When
Abdominal Pain					Kidney disease				
Abnormal Bleeding					Liver disease				
Arthritis					Lymph node disorder				
Asthma/Emphysema					Pacemaker				
Blackouts					Pneumonia				
Blood in Stool					Prostate disorders				
Breast disorders					Psychiatric disorder/depression				
Cancer type?					Skin disease				
Carotid Artery Disease					Spine disorders				
Changes in bowel habits					Stroke				
Colon Polyps					Thyroid disease				
Congestive Heart failure					Tuberculosis				
Diabetes					Ulcers-stomach/intestinal				
Gall Bladder					Urinary tract problems				
Glaucoma					Varicose veins				
Headache					Other				
Heart burn									
Heart attack									
Heart disease									
Hemorrhoids									
Hepatitis									
Hernia-what type									
High blood pressure									
High cholesterol									
Irregular Heartbeat									

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Past Medical History: _____

_____

_____

_____

Past Surgical History: _____

_____

Medications: _____

_____

Allergies: _____

_____

Social History:

Tobacco Use: Smoking ☐ Yes Amount _____ ☐ No ☐ Quit When _____
Chewing ☐ Yes Amount _____ ☐ No ☐ Quit When _____
Alcohol ☐ Yes How much/often _____ ☐ No
Street Drug Use ☐ Yes Type _____ ☐ No
Exercise regularly _____

Occupational:

Check (✓) If your work exposes you to the following:

☐ Stress ☐Hazardous Substances
☐Heavy Lifting ☐ Other

Occupation: _____

Workmen's Comp?

Is this condition related to:

EMPLOYMENT? (current or previous) ☐ Yes ☐ No
DATE OF OCCURRENCE _____
AUTO ACCIDENT? ☐ Yes ☐ No WHERE (State) _____
DATE OF OCCURRENCE _____
Are you receiving treatment from another physician or facility for

☐ Yes ☐ No If yes: Name of Physician or Facility

_____

Family History:
(Fill in health information about your family)

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:		
Father					✓	Disease:	Relationship:
Mother						Cancer	
Brother(s)						Diabetes	
						Heart Disease, Strokes	
						High Blood Pressure	
						Kidney Disease	
Sister(s)						Vascular Disease	
						Other	

Reviewed By Signature: _____

Date: _____