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: _____

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/Type_____					Ulcers-stomach/intestinal				
Gall Bladder					Urinary tract problems				
Glaucoma					Other				
Headache									
Heart burn									
Heart attack									
Heart disease									
Hemorrhoids									
Hepatitis									
Hernia-what type									
High blood pressure									
High cholesterol									
Irregular Heartbeat									

SAMUEL BUNDZ, M.D.

Past Surgical History: _____

_____

Medications: _____

_____

Allergies: _____

_____

Women:
Do you get yearly mammograms? _____
Age of menstruation: _____
Total number of pregnancies: _____
Age of first pregnancy: _____
Age of menopause: _____

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 _____					

Fall Risk:
Do you use a walker or cane? Yes/No
Have you fallen recently? Yes/No

Vaccines:
Have you had a flu vaccine this year? Yes/No
Have you had a Pneumonia vaccine this year? Yes/No
International Travel in the last 30 days? Yes/No

Is this Workmen's Comp? Yes/No

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: _____