MURAT BANKACI, M.D., P.C.

PATIENT HEALTH HISTORY FORM

Name__________________________________ Date of Birth______________ Date______________

MR # ____________________ Pharmacy ____

Current Medications (doses):

Allergies to Medications or Foods:

Previous Surgery:

RECENTLY HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS:
PLEASE RESPOND TO ALL QUESTIONS

Review of Systems

Constitutional

yes no weakness or fatigue
yes no recent weight loss

Eyes

yes no blurred vision
yes no double vision

Ears, Nose, Mouth and Throat

yes no trouble hearing
yes no tinnitus or ringing in ears
yes no ear pain
yes no ear infection or drainage
yes no dizziness, vertigo, or unsteadiness
yes no stuffy nose
yes no sinus trouble
yes no frequent nose bleeds
yes no frequent sore throats
yes no pain near teeth or mouth
yes no hoarseness or voice change
yes no difficulty with swallowing
yes no lumps in neck
yes no pain in the neck

Cardiovascular

yes no heart trouble
yes no palpitations
yes no high blood pressure

Respiratory

yes no cough
yes no asthma or wheezing
yes no shortness of breath

Hematologic

yes no easy bruising or bleeding
yes no anemia

Allergic

yes no hay fever or dust/mold allergy
yes no food sensitivity or intolerance
yes no chemical sensitivity

Gastrointestinal

yes no heartburn or acid reflux
yes no nausea or vomiting
yes no diarrhea
yes no ulcers
yes no frequent use of antacids

Genitourinary

yes no kidney problems

Musculoskeletal

yes no joint pains or stiffness

Integmentary

yes no skin rashes

Neurological

yes no headaches
yes no numbness in face, legs, or arms
yes no seizures
yes no weakness of arms or legs
yes no blackouts or fainting
yes no trouble speaking
yes no confusion or memory loss

Psychiatric

yes no nervousness or increased stress
yes no sleep problem
yes no excessive moodiness or worry

Endocrine

yes no thyroid trouble
yes no diabetes

(over...)

Past Medical History

DO YOU HAVE, OR HAVE YOU EVER HAD…

yes	no	Heart Disease (heart attack, angina, heart surgery, arrhythmia)	yes	no	Liver or Gallbladder trouble
			yes	no	Head Trauma
			yes	no	Stroke or TIA
yes	no	Diabetes (insulin, pills, diet control)	yes	no	Migraine Headaches
			yes	no	Seizure
yes	no	Lung Disease (asthma, emphysema, chronic bronchitis)	yes	no	Anxiety Disorder
			yes	no	Depression
yes	no	High Blood Pressure	yes	no	Panic attacks
yes	no	Thyroid Problems	yes	no	Arthritis
yes	no	Kidney Trouble	yes	no	Glaucoma
yes	no	Cancer	yes	no	Macular Degeneration

Social History

Line of Work/Job

Marital Status: Single____ Married____ Divorced____ Widowed____

Children (age):

yes no Do you use tobacco (____packs/____ day;____ years) Quit____years ago____

yes no Do you use alcohol (____drinks/day/week/weekend/month)

yes no Do you use coffee, tea or caffeine containing beverages (____cups/day)

Family History

IF ANY BLOOD RELATIVE HAVE HAD ANY OF THE FOLLOWING, PLEASE CIRCLE AND INDICATE WHICH RELATIVE

Heart Disease	Migraine	Mental Illness	Epilepsy
Diabetes	Thyroid	Voice Problems	Bleeds Easily
Hearing Loss	Stroke	Dizziness	Cancer

Hereditary Disorder: ______________________________

Patient's Signature: ______________________________ Date ______________

Please do not write below this line

I ______________________________ have reviewed my medical history form dated ______________, the form is current and up to date with no changes to be made.

______________________ DATE

______________________ PATIENTS SIGNATURE

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______________________ DATE

______________________ PATIENTS SIGNATURE