Medical History Review

Last Name: First Name: Account:
DOB: Sex:

Roseman Medical Group
5380 S. Rainbow Blvd.
Ste. 120
Las Vegas, NV 891181878
Phone: (702)463-4040
Fax: (702)968-5681

Please review the information below and write in any corrections or missing information.

PATIENT INFORMATION

DOB	**Address**
Age	
Marital Status	**Phone**
Emerg. Contact	**Insurance**
Emerg. Phone	**Policy #**
	Group #

ALLERGIES

Name	Reaction/Severity

MEDICAL HISTORY

Have you been diagnosed with any of the following diseases or had any of the following problems? Please circle Yes or No. Use the notes column to specify when you were diagnosed with that disease or when you last had symptoms.

Name	Yes	No	Notes
Angina	Yes	No	
Aortic Stenosis	Yes	No	
Asthma	Yes	No	
Atrial Fibrillation	Yes	No	
Bipolar Disorder	Yes	No	
Bone Cancer	Yes	No	
Brain Cancer	Yes	No	
Breast Cancer	Yes	No	
COPD	Yes	No	
Chronic Bronchitis	Yes	No	
Chronic Kidney Disease	Yes	No	
Chronic Lower Respiratory Disease	Yes	No	
Colon Cancer	Yes	No	
Congestive Heart Failure	Yes	No	
Depression	Yes	No	
Diabetes	Yes	No	
Eating Disorder	Yes	No	
Emphysema	Yes	No	
Esophageal Cancer	Yes	No	
Gastric Cancer	Yes	No	
Gestational Diabetes	Yes	No	
Hallucinations & Delusions	Yes	No	
Heart Attack	Yes	No	
Heart Disease	Yes	No	
Insomnia	Yes	No	

Kidney Cancer	Yes	No	
Leukemia	Yes	No	
Liver cancer	Yes	No	
Lung Cancer	Yes	No	
Mental Disorder	Yes	No	
Multiple Sclerosis	Yes	No	
Muscle Cancer	Yes	No	
Ovarian Cancer	Yes	No	
Pancreatic cancer	Yes	No	
Panic Disorder	Yes	No	
Personality Disorder	Yes	No	
Post Traumatic Stress Disorder	Yes	No	
Prediabetes	Yes	No	
Prostate Cancer	Yes	No	
Psychosis	Yes	No	
Rectal Cancer	Yes	No	
Restless Leg Syndrome	Yes	No	
Schizophrenia	Yes	No	
Skin Cancer	Yes	No	
Sleep Apnea	Yes	No	
Social Phobia	Yes	No	
Thyroid Cancer	Yes	No	
Type 1 Diabetes	Yes	No	
Type 2 Diabetes	Yes	No	
Uterine Cancer	Yes	No	
_____	Yes		
_____	Yes		
_____	Yes		

FAMILY HISTORY

Has any of your family members been diagnosed with any of the following diseases? Please circle Yes or No. If you answer Yes, please specify which family members were diagnosed with each disease.

Name	Yes	No	Relatives/Notes
Alzheimer's Disease	Yes	No	
Dementia	Yes	No	
Diabetes	Yes	No	
Epilepsy	Yes	No	
Frontotemporal Dementia	Yes	No	
Lewy Body Dementia	Yes	No	
Multiple Sclerosis	Yes	No	
Parkinson's Disease	Yes	No	
Stroke	Yes	No	
Type 1 Diabetes	Yes	No	
Type 2 Diabetes	Yes	No	
_____	Yes		
_____	Yes		
_____	Yes		

SMOKING

Please place a check by the sentence that best describes your smoking status:

I have never smoked: _____ I used to smoke: _____

I currently smoke every day: _____ I currently smoke on some days: _____

SURGICAL/HOSPITALIZATION HISTORY

Please list dates you were hospitalized and the reason for each hospitalization.

Date	Hospitalization Reason/Surgery

CURRENT MEDICATIONS

Please list any medications you are currently taking. Please include the strength of the pill (eg Ibuprofen 250mg). Also list any over-the-counter (OTC) medications you have recently taken.

Drug Name & Strength	Frequency/Instructions	Prescribing Dr

Pharmacy: _____ **Phone:** _____ **Fax:** _____