James H. Brodsky, MD, PC
4701 Willard Avenue, Suite 224
Chevy Chase, Maryland 20815
T: 301-652-6760 | F: 301-652-6763

PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Last Name:	First Name:	Middle:	
Birth Date:	Country of Birth:		
Address:	City:	State:	Zip:
Medicare No. (If Applicable):	Occupation:		
Cell Phone:	Home Phone:	Business Phone:	
Health Insurance Company:		Insurance No:	
Sex: M F	Marital Status:	Religion:	
Person to Notify:		Relationship:	
Address:		Phone No:	
Date of Last Physical Examination:		Referred by:	
Employer:			
Email:			

LIFESTYLE &WELLNESS MEDICINE

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FAMILY HISTORY

Name	If Living:		If Deceased:	
Father:	Age:	Health:	Age at Death	Cause
Mother:				
Brothers/Sisters (circle sex)				
M F				
M F				
M F				
M F				
M F				
Husband/Wife				
Sons/Daughters (circle sex)				
M F				
M F				
M F				
M F				
M F				

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FAMILY HISTORY

Check if any blood relative has or has had any of the following enter relationship.

	Yes	No	Rel.		Yes	No	Rel.		Yes	No	Rel.
Stoke	☐	☐		Migraine	☐	☐		Goiter	☐	☐	
Cancer	☐	☐		Asthma	☐	☐		Arthritis	☐	☐	
High Blood				Hay Fever	☐	☐		Colitis	☐	☐	
Pressure	☐	☐		Emphysema	☐	☐		Gout	☐	☐	
Tuberculosis	☐	☐		Bleeding				Rheumatic			
Diabetes	☐	☐		Tendency	☐	☐		Heart	☐	☐	
Leukemia	☐	☐		Heart Attack	☐	☐		Congenital			
Epilepsy	☐	☐		Stomach Ulcers	☐	☐		Heart	☐	☐	
Mental Illness	☐	☐		Kidney Disease	☐	☐					

PAST HISTORY (Personal)
Have you had any of the following illnesses?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Cancer	☐	☐
Angina Pectoris	☐	☐	Frequent Kidney/Bladder		
Heart Attack	☐	☐	Infections	☐	☐
Other Heart Disease	☐	☐	Nervous Breakdown	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Anemia	☐	☐	Stomach Ulcers	☐	☐
Kidney Disease	☐	☐	Gallbladder Disease	☐	☐
Gout	☐	☐	Jaundice	☐	☐
Hay Fever	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Colitis	☐	☐
Frequent Lung			Arthritis	☐	☐
Infections	☐	☐	Migraine Headache	☐	☐
Emphysema	☐	☐	Others	☐	☐
Diabetes	☐	☐	_____		
			_____		
			_____		

Operations: List and indicate approximate year.

_____ _____

_____ _____

_____ _____

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Hospitalizations (other than operations): List reasons and approximate dates.

_____ _____

_____ _____

_____ _____

_____ _____

Serious injuries (other than the above): List and give approximate dates.

_____ _____

_____ _____

_____ _____

_____ _____

Diagnostic X-Rays: List and give approximate dates.

_____ _____

_____ _____

_____ _____

_____ _____

Immunizations: Please give dates or bring records.

Tetanus _____ Hepatitis B_____ Pneumonia _____

Hepatitis A _____ Other _____

Are you allergic to any medication: Yes ☐ No ☐

If yes, please list the medications and the reaction you had to them:

_____ _____

_____ _____

_____ _____

_____ _____

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PERSONAL HABITS

1. Check if you regularly smoke:
   ☐ Cigarettes: Number per day _____ ☐ Pipe ☐ Cigars
   How long have you been smoking? _____ years

2. Check if you regularly drink:

☐ Hard Liquor	1- 3 oz. per day ☐	Over 3 oz. per day ☐	
☐ Beer	1 bottle per day ☐	2 bottles ☐	3 or more ☐
☐ Wine	1 glass per day ☐	2 glasses ☐	3 or more ☐

3. Do you drink coffee? Yes ☐ No ☐ 3 or more cups ☐

4. Do you have difficulty sleeping? Never ☐ Often ☐ Sometimes ☐

5. Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again?
   Frequently ☐ Occasionally ☐ Rarely ☐

6. Describe your exercise: _____

   _____

MEDICATIONS:

Please list all drugs, vitamins, and or supplements you are taking:

_____

_____

_____

_____

_____

_____

ALLERGIES
(Other than medication)

☐ Dust
☐ Mold
☐ Pollen
☐ Trees
☐ Others:

Chemicals
_____

Foods
_____

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OCCUPATIONAL:

	Yes	No	Additional Information
Are you presently unemployed?	☐	☐	_____
Are you dissatisfied with your present type of work?	☐	☐	_____
Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐	_____
Do you have more than one job?	☐	☐	_____
Do you work more than 60 hours a week?	☐	☐	_____
Do you get along poorly with your fellow employees and/or your supervisors?	☐	☐	_____
Are you unable to perform any work because of disability?	☐	☐	_____
Are you retired?	☐	☐	_____
If retired, have you had difficulty adjusting to retirement?	☐	☐	_____
If a housewife, do you find your housework difficult?	☐	☐	_____
If a housewife, are you unhappy with your housework?	☐	☐	_____

MARITAL/FAMILY:

	Yes	No	Additional Information
Have you been married more than one time?	☐	☐	_____
Has there been a recent change in your marital status?	☐	☐	_____
Does your age and your spouse's age differ by more than 10 yrs.?	☐	☐	_____
Are there any problems with your married life?	☐	☐	_____
Do you have any sex problems?	☐	☐	_____
If a widow or widower, have you had difficulty adjusting to your spouse's death	☐	☐	_____
Do you have any serious problems with your children?	☐	☐	_____
Is your present home life causing unhappiness?	☐	☐	_____
Have there been any deaths in your family or among close friends in the past year or two?	☐	☐	_____
Does anyone in your family have a serious illness or disability?	☐	☐	_____
Does anyone in your family have a drug or alcohol problem?	☐	☐	_____

SOCIAL HISTORY:

	Yes	No	Additional Information
Have you recently lived or traveled outside the U.S.?	☐	☐	_____
Did you complete high school education?	☐	☐	_____
Did you attend and/or complete college?	☐	☐	_____
Were you rejected from the Military Service?	☐	☐	_____
Have you ever been rejected for life or health insurance or had to pay an extra premium?	☐	☐	_____
Do you eat less than three meals a day?	☐	☐	_____
Do you have special food customs or restrictions?	☐	☐	_____
Have you ever been treated for a drinking problem?	☐	☐	_____
Do you exercise less than three times a week?	☐	☐	_____
Do you have a hobby or hobbies?	☐	☐	_____
Are you active in political, community or church activities?	☐	☐	_____

Please identify your hobby or hobbies:

_____

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REVIEW OF SYSTEMS:

A. GENERAL	Yes	No	Additional Info
Do you worry a lot about your health?	☐	☐	_____
Do you usually feel tired or worn out?	☐	☐	_____
Do you feel depressed a lot of the time?	☐	☐	_____
Have you recently noticed that heat or warm weather bothers you?	☐	☐	_____
Have you recently been drinking more water or fluids?	☐	☐	_____
Has there been any unusual weight gain or loss recently?	☐	☐	_____

B. SKIN			
Have you noticed:	Yes	No	Additional Info
Any change in the color of your skin?	☐	☐	_____
Any skin rashes or itching?	☐	☐	_____
Unusually dry skin?	☐	☐	_____
Any growth on your skin that bothers you?	☐	☐	_____
Any sores or wounds that do not heal?	☐	☐	_____
Any change in color or size of warts?	☐	☐	_____

C. EYES			
Have you had:	Yes	No	Additional Info
Any pain in your eyes?	☐	☐	_____
Glaucoma?	☐	☐	_____
Blurry vision?	☐	☐	_____
Halos around lights?	☐	☐	_____
Change in vision?	☐	☐	_____

D. ENT			
Do you have:	Yes	No	Additional Info
Any trouble hearing?	☐	☐	_____
Ringing or buzzing in your ears?	☐	☐	_____
Earaches or discharge from your ears?	☐	☐	_____
A lot of nasal stuffiness?	☐	☐	_____
Drainage down the back of your throat?	☐	☐	_____
Frequent or severe nosebleeds?	☐	☐	_____
Persistent hoarseness?	☐	☐	_____
A lump in your throat?	☐	☐	_____
A sore tongue or mouth?	☐	☐	_____
Bleeding gums?	☐	☐	_____

E. RESPIRATORY			
Do you have:	Yes	No	Additional Info
Frequent chest colds?	☐	☐	_____
A constant or bothersome cough?	☐	☐	_____
Coughing of blood?	☐	☐	_____
Sputum or phlegm between colds?	☐	☐	_____
Difficulty Breathing?	☐	☐	_____
Have you notice any wheezing or whistling in your chest?	☐	☐	_____

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F. CARDIOVASCULAR	Yes	No	Additional Info
Do you have pain, tightness or pressure in the front or back of your chest?	☐	☐	_____
If yes, is it when walking fast, working hard or when excited?	☐	☐	_____
Have you ever been told that your electrocardiogram was abnormal?	☐	☐	_____
Do you have swelling of your feet or ankles?	☐	☐	_____
Does your heart ever beat fast or irregularly?	☐	☐	_____
Do you have cramps in the calf muscles when you walk?	☐	☐	_____
Do you ever awaken at night with severe difficulty breathing?	☐	☐	_____
Do your fingers or toes ever get cold, become numb or get very white or blueish?	☐	☐	_____

G. GASTROINTESTINAL	Yes	No	Additional Info
Have you recently had any change in your eating habits?	☐	☐	_____
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc.?	☐	☐	_____
Do you tend to burp a lot?	☐	☐	_____
Have you recently noted any trouble swallowing?	☐	☐	_____
Do you have a lot of indigestion or heartburn?	☐	☐	_____
Have you ever vomited blood?	☐	☐	_____
Are you bothered with constipation?	☐	☐	_____
Do you have frequent loose stools or diarrhea?	☐	☐	_____
Do you pass a lot of gas?	☐	☐	_____
Do you have a poor appetite?	☐	☐	_____
Do you ever awaken at night with the feeling of fullness underneath your breast bone?	☐	☐	_____
Have you ever passed blood from your rectum?	☐	☐	_____
Have you ever had black or tarry stools?	☐	☐	_____
Have you noticed any recent changes in your bowel movements?	☐	☐	_____
Do you take laxatives regularly?	☐	☐	_____
Do you have frequent nausea and/or vomiting?	☐	☐	_____

H. GENITOURINARY Do you have:	Yes	No	Additional Info
Anything wrong with your genitals (privates)?	☐	☐	_____
Burning or pain when you urinate?	☐	☐	_____
To pass water frequently?	☐	☐	_____
To pass more water than you are used to?	☐	☐	_____
Trouble passing water?	☐	☐	_____
To get up at night or urinate?	☐	☐	_____
Trouble with losing urine when you cough or sneeze?	☐	☐	_____
A problem dribbling urine?	☐	☐	_____
Have you ever passed blood in your urine?	☐	☐	_____
Have you had an operation to prevent pregnancy?	☐	☐	_____
(Vasectomy or sterilization, such as tubal ligation?)	☐	☐	_____
Men, do you have prostate gland trouble?	☐	☐	_____

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I. MUSCULOSKETAL

	Yes	No	Additional Info
Do you have a problem with back pain?	☐	☐	_____
Do you have pain in your legs or feet?	☐	☐	_____
Does back pain interfere with your work or activities?	☐	☐	_____
Do you have joint pain or stiffness?	☐	☐	_____
Do you have trouble walking or using your hip or knee joints?	☐	☐	_____

J. CENTRAL NERVOUS SYSTEM

	Yes	No	Additional Info
Do you have frequent or severe headaches?	☐	☐	_____
Do you often have spells of dizziness or faintness or lightheadedness?	☐	☐	_____
Have you ever seen double?	☐	☐	_____
Is your memory or concentration impaired?	☐	☐	_____
Do you sometimes lose the ability to speak for a few seconds?	☐	☐	_____
Have you recently fainted, blacked out or lost consciousness?	☐	☐	_____
Do you have trouble remembering recent events?	☐	☐	_____
Have you ever had convulsions or fits?	☐	☐	_____
Do you have numbness or tingling in your head, arms or legs?	☐	☐	_____
Do you consider yourself a nervous person?	☐	☐	_____
Are you depressed?	☐	☐	_____
Have you ever had an urge to commit suicide?	☐	☐	_____
Do you ever hear voices or see people when no one is around?	☐	☐	_____
Do you ever have a feeling that someone is trying to harm you?	☐	☐	_____

K. WOMEN ONLY:

How many times have you conceived? _____
How many full-term deliveries? _____
How many miscarriages? _____
How many abortions? _____

	Yes	No	Additional Information
Did you ever take birth control pills?	☐	☐	_____
If yes, for how many years? _____			
Do you have vaginal itching?	☐	☐	_____
Have you had recurrent vaginal yeast infections?	☐	☐	_____
If yes, estimate how many? _____			
Do you have any lumps in your breasts?	☐	☐	_____
Do you have any nipple discharge?	☐	☐	_____
Do you have hot flashes?	☐	☐	_____
Have you passed menopause?	☐	☐	_____
If yes, age at menopause _____			
If you are still menstruating:			
Are your periods irregular?	☐	☐	_____
Do you have pre-menstrual depression or tension?	☐	☐	_____
Do you become bloated before your period?	☐	☐	_____
Do you feel your menstrual flow is heavy?	☐	☐	_____
Current form of contraception _____			

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Important Topics to Discuss:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____