VICTOR P. KRESTOW, M.D., P.A.
NORLAND MEDICAL CENTER
SEVEN N.W. 183rd STREET
MIAMI, FLORIDA 33169-4574
(305) 652-3614

New Patient Medical History Form

Please complete all information on this form to the best of your knowledge. If none in a particular section, write N/A or none.

Patient Name _____

Date of Birth _____ Date form completed _____

Past Medical History *(check all items that you have had in the past)*:

- ☐ Alcohol abuse
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clot
- ☐ Blood Disease
- ☐ Bowel Disease
- ☐ Cancer _____
- ☐ Chronic Pain
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Ear Problem
- ☐ Eye Problem
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heartburn
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Joint Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Problem
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscle Problem
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Psychiatric Disorder
- ☐ Seizure Disorder
- ☐ STD _____
- ☐ Skin Problem
- ☐ Stroke
- ☐ Thyroid Disease

Past Surgical History *(check all surgeries that you have had and circle corresponding side, right or left)*:

- ☐ Appendectomy *(Appendix)*
- ☐ Breast Augmentation
- ☐ Breast Biopsy: R / L
- ☐ Breast Lumpectomy: R / L
- ☐ Breast Mastectomy: R / L
- ☐ Cataract Removal: R / L
- ☐ Cholecystectomy *(Gall Bladder)*
- ☐ Coronary Artery Bypass _____ # of vessels
- ☐ Hysterectomy (Total)
- ☐ Hysterectomy *(Partial)*
- ☐ Inguinal Hernia Repair: R / L
- ☐ Laminectomy *(Cervical)*
- ☐ Laminectomy *(Lumbar)*
- ☐ Prostatectomy *(Prostate)*
- ☐ Thyroidectomy *(Thyroid)*
- ☐ Tonsillectomy *(Tonsils)*
- ☐ Umbilical Hernia repair
- ☐ Vasectomy
- ☐ Other

Past Hospitalization History *(include reason for hospitalization and the year)*:

_____

_____

_____

_____

Family History

Does your mother, father, grandparents, brothers, sisters, aunts, uncles or children have any of the following? If yes, who? If family history is unknown, please check unknown.

- ☐ Cancer who: _____
- ☐ Diabetes who: _____
- ☐ Drinking Problems who: _____
- ☐ Drug Problems who: _____
- ☐ Heart Problems who: _____
- ☐ High Blood Pressure who: _____
- ☐ Learning Problems who: _____
- ☐ Lung Problems (asthma who: _____
- ☐ Mental illness (depression) who: _____
- ☐ Unknown/Adopted

Present Medications *(list the name and dose of each medication you are currently taking):*

Please also bring ALL of your medications with you to your appointment, including supplements and over the counter medicines.

☐ None _____

_____

_____

_____

Pharmacy name _____ Phone Number _____

Other Physicians *(list the names of other physicians you see and why they are treating you):*

☐ None _____

_____

_____

_____

_____

Health Studies *(check all items that you have had in the past five years and include the date/year):*

☐ Head CT _____

☐ Spine CT _____

☐ Brain MRI _____

☐ Spine MRI _____

☐ Spinal tap _____

☐ Bone Scan _____

☐ EEG _____

☐ EMG/NCV _____

☐ Tomograms _____

☐ Myelogram _____

☐ Evoked responses _____

☐ Endocrine tests _____

☐ X-rays | Type: _____

☐ Angiogram (cardiac cath) | Type: _____

List all Health Maintenance studies/procedures you have had in the past 5 years (for example: PAP Smear, Mammogram, PSA, EKG, Colonoscopy).

_____

_____

_____

_____

_____

_____

Patient Signature Date