Duc H. Do, M.D., F.A.C.E. 520 Superior Ave, # 200, Newport Beach CA 92663

CONFIDENTIAL MEDICAL HISTORY

Name:____Date:_______________

Address: ____Marital status: S M W D

Number Street City State Zip code

Phone number: (_______)__________________ (______)__________________Date of birth: ____ /___ /_____ Age:_________

Day Night

Fax number: (_______)________________ E-mail address:_________________________________(for non-urgent, non- clinical matters only)

Occupation:_________________________________ Referring physician:___________________________________

Ref. physician FAX #:(…….) ………-…………

Physicians involved in your care & reasons for their involvement:

1.____ 4.____

2.____ 5.____

3.____ 6.____

Reasons for consultation with Dr. Duc Do:

____

____

____

PAST MEDICAL HISTORY

Have you had any of the following? If yes, give details:

NEUROLOGY	No	Y	✯ *ENDOCRINOLOGY*	No	Y	*RESPIRATORY*	No	Y
Seizures			Diabetes?, if yes, since what year:…..			New cough		
Poor concentration						Wheezing		
Memory loss			Insulin use for diabetes			Coughing up blood		
Vertigo			Diabetes Education			Asthma		
Strokes			Any dietary restriction			*HEMATOL/ONCOLOGY*	No	Y
Visual changes			Low carbohydrate diet			Anemia		
Easy irritability			Diabetes in pregnancy			Leukemia		
New headache			Goiter			Bleeding disorders		
Unexplained fatigue			Thyroid nodule			Cancer of organs		
Afternoon somnolence (sleepiness)			Underactive thyroid			*MUSCULO-SKELETAL*	No	Y
Non-refreshing sleep			Overactive thyroid			Hand Shakiness		
EAR NOSE THROAT, NECK	No	Y	Any other thyroid disorder			Rheumatoid arthritis		
RADIATION TREATMENT			Surgery on thyroid			Osteoarthritis		
Pain in the front neck			Cold intolerance			Lupus		
Neck swelling			Heat intolerance			Any muscle disorders		
Difficulty in swallowing			Difficulty losing weight			Osteoporosis		
Hoarseness of voice			Unintentional weight loss			Broken bones not from injury		
Loud snoring			Calcium disorder			*SKIN/HAIR*	No	Y
CARDIOVASCULAR	No	Y	Pituitary gland disorders			Dry skin		
Heart irregularity			Diabetes insipidus			Skin color changes		
Heart palpitation			Excessive hunger			Brittle nails		
Heart attack			Excessive sweating			Abnormal hair loss		
Heart failure			Easy bruising			Abnormal hair growth		
Heart surgery			Excessive thirst			Acne		
Angina			Excessive urination			*GENITO-URINARY*	No	Y
Heart valve problem			Recent breast size changes (F)			Kidney stones		
Shortness of breath			Unusual discharge from breast			Kidney infection		
GASTROINTESTINAL	No	Y	Menstrual changes			Blood in urine		
Stomach/duodenal ulcers			Hot flashes			Disease of uterus (F)		
Bleeding from stomach			Abortions			Difficulty w/erection (M)		
Gallstones			Difficulty conceiving children			Absence of erection at night		
Nausea /Vomiting			Menstrual irregularity			Prostate enlargement		
Frequent bowel movements			Lack of desire for sex			Prostate cancer		
Constipation			Disease of ovaries (F)			Disease of the testes		

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CONFIDENTIAL MEDICAL HISTORY

Name:____Date:______________

What is your age of onset of periods?		ANY MAJOR PROCEDURES/HOSPITALIZATIONS ?	What year?
What is interval between menstrual periods?			
What is age of menopause, if applicable?			

List any other past medical history:

____

FAMILY HISTORY:

List family members who have had the following:	Diabetes, if yes type 1 or 2?	Thyroid disease	Heart illness	High blood pressure	Cancer	Any hereditary disease

Relationship	Age	Any Illness ?	Alive/Dead		Cause of death
Father					
Mother					
Brother					
Brother					
Sister					
Sister					
Son					
Daughter					

SOCIAL HISTORY:

- Do you exercise regularly? If yes what do you do?_______________________________
- Have you followed a diet program?_______________________________
- Have you used tobacco?, If yes, when & how much a day?_______________________________
- Have you used alcohol? If yes, when & how much a day?_______________________________
- Have you used any illicit drugs? If yes, please list_______________________________

ALLERGY: List all allergies to any agent or medication **(or indicate NONE)**:_______________________

Also indicate what kind of reactions?: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

LIST ALL MEDICATIONS/VITAMINS YOU ARE TAKING (Please list all medications taken, including prescription drugs, vitamins, dietary supplements, over-the-counter products, health food products, etc.):

NAME	STRENGTH	HOW OFTEN	DATE STARTED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			