Eli Chen, M.D.
333 O'Connor Drive, San Jose, CA 95128
(408) 297-3484 (phone) / (408) 292-6481 (fax)

Name:
DOB:

Reason for Today's Visit: _____

When did you first become aware of this problem? _____ Height:_____

Who may we thank for referring you? _____ Weight:_____

Medical History:

	YES	NO		YES	NO
Anemia	___	___	Hypothyroidism	___	___
Atrial Fibrillation	___	___	Irritable Bowel Syndrome	___	___
Arthritis (specify)	___	___	Liver Disease	___	___
Bleeding Disorders (specify)	___	___	Myocardial Infarction	___	___
Blood Clots	___	___	Neuropathy	___	___
Cancer (specify)	___	___	Peripheral Vascular Disease	___	___
Carotid Artery Disease	___	___	Peptic Ulcer Disease	___	___
Congestive Heart Failure	___	___	Renal Disease	___	___
COPD / Asthma	___	___	Seizure Disorder	___	___
Diabetes Mellitus	___	___	Skin Problems (specify)	___	___
Heart Valve Disorder (specify)	___	___	Sleep Apnea	___	___
HIV/AIDS	___	___	Tuberculosis	___	___
Hypertension	___	___	Other	___	___

Do you have any allergies to medications? Yes ___ No ___ If so, please list each medication *and reaction.*

_____ _____

_____ _____

Please list all medications/supplements you currently take, ***including dosage and frequency***.

Medication	Dose	Frequency	Medication	Dose	Frequency

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Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had problems with general anesthesia? Yes ___ No ___ If so, please specify:

_____

Family History: Does anybody in your immediate family have any of the following medical conditions?

	Mother	Father	Sibling(s)	Son(s)/Daughter(s)	Other (specify)
Cancer (please specify)	___	___	___	_____	_____
Diabetes	___	___	___	_____	_____
Epilepsy/Seizures	___	___	___	_____	_____
Heart Disease	___	___	___	_____	_____
High Blood Pressure	___	___	___	_____	_____
Immune Disorder	___	___	___	_____	_____
Stroke	___	___	___	_____	_____

Social History:

Tobacco Use: Yes ___ No ___

Cigarettes: Packs per day_____ How many years?_____ If you quit, when? _____

Other (specify):_____ Amount per day_____ How many years?_____ If you quit, when? _____

Alcohol Use: Yes ___ No ___

If yes, please specify what type and how often: _____

Do you use any drugs other than prescribed or over the counter medication? Yes ___ No ___

If yes, please list: _____

Indicate any other important information that you feel the doctor should know: _____

_____

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Review of Systems:

Constitutional:	Yes	No
good health	___	___
recent weight gain/loss	___	___
recurrent fevers, chills, sweats	___	___
fatigue	___	___
difficulty sleeping	___	___
Eyes:		
blurred or double vision	___	___
dimished visual acuity	___	___
eye pain	___	___
Ears/Nose/Mouth/Throat:		
decreased hearing	___	___
ringing in the ears	___	___
recent nose bleeds	___	___
voice change/hoarseness	___	___
Respiratory:		
asthma or wheezing	___	___
breathing problems	___	___
coughing up blood	___	___
chronic cough	___	___
recent pneumonia	___	___
Cardiovascular:		
chest pain, tightness or pressure	___	___
heart pain or heart attack	___	___
exertional shortness of breath	___	___
shortness of breath lying flat	___	___
heart racing/palpitations	___	___
swelling of feet/ankles	___	___
blood clots	___	___
Gastrointestinal:		
changes in appetite	___	___
severe heartburn	___	___
bleeding ulcers	___	___
frequent nausea/vomiting	___	___
frequent diarrhea	___	___
constipation	___	___
rectal bleeding	___	___
abdominal pain	___	___

Genitourinary:	Yes	No
blood in urine	___	___
pain/burning with urination	___	___
urinary tract infections	___	___
kidney stones	___	___
Neurologic:		
headaches	___	___
numbness or tingling sensations	___	___
weakness or paralysis	___	___
convulsions or seizures	___	___
changes in memory/concentration	___	___
loss of balance/coordination	___	___
difficulty speaking	___	___
Psychiatric:		
anxiety/agitation/nervousness	___	___
depression	___	___
excessive energy	___	___
suicidal thoughts/ideation	___	___
Musculoskeletal:		
difficulty walking	___	___
back pain	___	___
neck pain	___	___
joint stiffness (specify)	___	___
muscle pain (specify)	___	___
joint swelling (specify)	___	___
Endocrine:		
heat or cold intolerance	___	___
excess thirst or urination	___	___
thyroid problems	___	___
Allergy/Immunology		
eczema	___	___
hives	___	___
low resistance to infection	___	___
recent cold/flu	___	___
environmental allergies	___	___
Hematologic/Lymphatic		
easy bruising	___	___
frequent or prolonged bleeding	___	___
enlarged lymph nodes	___	___