

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	Genitourinary:	Yes	No
good health	___	___	blood in urine	___	___
recent weight gain/loss	___	___	pain/burning with urination	___	___
recurrent fevers, chills, sweats	___	___	urinary tract infections	___	___
fatigue	___	___	kidney stones	___	___
difficulty sleeping	___	___			
			Neurologic:		
Eyes:			headaches	___	___
blurred or double vision	___	___	numbness or tingling sensations	___	___
diminished visual acuity	___	___	weakness or paralysis	___	___
eye pain	___	___	convulsions or seizures	___	___
			changes in memory/concentration	___	___
Ears/Nose/Mouth/Throat:			loss of balance/coordination	___	___
decreased hearing	___	___	difficulty speaking	___	___
ringing in the ears	___	___			
recent nose bleeds	___	___	Psychiatric:		
voice change/hoarseness	___	___	anxiety/agitation/nervousness	___	___
			depression	___	___
Respiratory:			excessive energy	___	___
asthma or wheezing	___	___	suicidal thoughts/ideation	___	___
breathing problems	___	___			
coughing up blood	___	___	Musculoskeletal:		
chronic cough	___	___	difficulty walking	___	___
recent pneumonia	___	___	back pain	___	___
			neck pain	___	___
Cardiovascular:			joint stiffness (specify)	___	___
chest pain, tightness or pressure	___	___	muscle pain (specify)	___	___
heart pain or heart attack	___	___	joint swelling (specify)	___	___
exertional shortness of breath	___	___			
shortness of breath lying flat	___	___	Endocrine:		
heart racing/palpitations	___	___	heat or cold intolerance	___	___
swelling of feet/ankles	___	___	excess thirst or urination	___	___
blood clots	___	___	thyroid problems	___	___
Gastrointestinal:			Allergy/Immunology		
changes in appetite	___	___	eczema	___	___
severe heartburn	___	___	hives	___	___
bleeding ulcers	___	___	low resistance to infection	___	___
frequent nausea/vomiting	___	___	recent cold/flu	___	___
frequent diarrhea	___	___	environmental allergies	___	___
constipation	___	___			
rectal bleeding	___	___	Hematologic/Lymphatic		
abdominal pain	___	___	easy bruising	___	___
			frequent or prolonged bleeding	___	___
			enlarged lymph nodes	___	___