



JACK ZOLDAN, M.D., LTD

BOARD CERTIFIED in INTERNAL MEDICINE
5015 N. Paulina Suite 315 ● Chicago, IL 60640
TEL: (773) 561-6573 ● FAX: (773) 561-8323
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MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____

Your answers on this form will help Dr. Zoldan understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Please give your best estimates if you cannot remember specific details. **Thank you!**

PLEASE PRINT

How would you rate your general health? Excellent Good Fair Poor

Please describe a brief history of your present health concerns. Include the dates of onset and your symptoms. We will discuss this in detail during the visit: _____

REVIEW OF SYSTEMS: Please check any current symptoms you have on the list below.

Constitutional

- Fevers/sweats/chills
- Unexplained weight loss/gain
- Fatigue/weakness
- Excessive thirst of urination

Eyes

- Change in vision

Ears/Nose/Throat/Mouth

- Difficulty hearing/ringing in ears
- Hay fever/allergies
- Frequent colds/sinusitis
- Trouble swallowing

Cardiovascular

- Chest pain/discomfort
- Short of breath with exertion
- Palpitations

Breast

- Breast lump/discharge

Endocrine

- Cold/heat intolerance

Respiratory

- Cough/wheezing
- Difficulty breathing

Gastrointestinal

- Heartburn/reflux
- Blood in bowel movement
- Change of bowel habit
- Diarrhea/constipation
- Abdominal pain
- Nausea/vomiting

Genitourinary

- Painful/bloody urination
- Nighttime urination
- Leaking urine
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sexual functions

Other (please specify) _____

Musculoskeletal

- Muscle/joint pain
- Joint swelling

Skin

- Rash or mole change

Neurological

- Headaches
- Memory loss
- Fainting
- Dizziness/lightheaded

Psychiatric

- Anxiety/stress
- Depression
- Problems with sleep

Blood/Lymphatic

- Unexplained lumps
- Easy bruising
- Bleeding



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ALLERGIES

Please list any medication, food, or other allergies. Include the type of reaction if known: _____

MEDICATIONS

List all current medications and dosages. Include over-the-counter medicines and vitamins/herbs that you take regularly:

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical conditions (with approximate date of onset of illness/diagnosis):

- | | |
|---|--|
| <input type="checkbox"/> Heart disease (Please specify type) _____ | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma/Lung disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Cancer (please specify) _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Have you get frequent infections? | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Have you (past or present) taken frequent antibiotics? | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Other (please specify) _____ | |

SURGICAL HISTORY: Please list all prior operations and procedures (with dates): _____

WOMEN'S GYNECOLOGIC HISTORY:

of Pregnancies: _____ # of Deliveries: _____ # of Abortions: _____ # of Miscarriages: _____

1st day, most recent period: _____ Age at first period: _____ Frequency of periods: _____ Length of each: _____

Do you have symptoms with or concerns about your period? NO YES _____

Do you have concerns about menopause? NO YES _____

FAMILY HISTORY:

Mother's health: _____ Father's health: _____

Siblings' health: _____

Do any family members have any of the following conditions?

- | | |
|------------------------------------|--------------------------|
| Cancer (please specify type) _____ | Heart Disease _____ |
| High Blood Pressure _____ | Stroke _____ |
| Diabetes _____ | High Cholesterol _____ |
| Genetic Disorders _____ | Depression/suicide _____ |
| Asthma/COPD _____ | Other _____ |



SOCIAL HISTORY

Tobacco Use

Never smoked Current Smoker: # per day: _____ # of years: _____ Quit Date: _____

Other Tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? NO YES

Alcohol Use

Do you drink alcohol? NO YES # of drinks per week _____

Is your alcohol use a concern for you or others? NO YES

Driving Behavior

Do you text while you drive? NO YES

Recreational Drug Use

Do you use drugs? NO YES

Have you ever used needles to inject drugs? NO YES

Sexual Activity

Are you sexually active? NO YES Not currently

Sexual partner(s) is/are/have been: Male Female Do you have more than one sexual partner? NO YES

Method of birth control: _____

Have you ever had any sexually transmitted diseases (STDs)?

Are you interested in being tested for sexually transmitted diseases? NO YES

Caffeine intake: None Cups per day: Coffee _____ Tea _____ Soda _____ Other _____

Diet

Rate and describe your diet. _____ Estimate the amount of your fat and sodium (salt) intake. _____

Do you eat at restaurants a lot? NO YES

Do you eat a lot of prepared foods? NO YES

Exercise

Describe your exercise: _____

Immunizations

Hepatitis A Measles Mumps Rubella Pneumovax (Pneumonia)

Hepatitis B MMR Tetanus, Td, Tdap (tetanus & pertussis)

Shingles (Varicella) Other _____



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Socioeconomic

Occupation: _____ Years of education/highest degree: _____

Marital status (please check one): Single Partner/Married Divorced Widowed Other _____

Spouse/Partner's name: _____ Number of children: _____

Who lives at home with you? _____

Emotions

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed, or hopeless?

NO YES If YES, please explain: _____

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest in things that you usually cared about or enjoyed? NO YES

If YES, please explain: _____

Patient Signature: _____ Date: _____

Reason Patient is unable to sign and needs a Representative (Please Print)

Relationship of Patient Representative to the Patient (Please Print)

Patient Representative (Please Print)	Signature of Patient Representative	DOB	Date
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