Ward F. Cunningham-Rundles, M.D.
240 East 68TH Street
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(212) REgent 7-8973
(212) 737-8973
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DATE:

CONFIDENTIAL

PLEASE ANSWER THE FOLLOWING QUESTIONS (if you do not understand, ask the office staff; the doctor will go over these questions):

NAME:

ADDRESS:

HOME PHONE:	WORK PHONE:	OTHER NUMBERS:
OCCUPATION:		E-MAIL
BIRTH DATE:	MARITAL STATUS	NAME OF SPOUSE/OTHER

REFERRED BY (Patient or Health Professional):

INSURANCE:(policy number, insured's name, address of claim office and tel.number)

What is the reason for seeing a doctor? (Be specific.)

Have you ever been hospitalized? Where, when, and for what reason?

Have you had other illnesses? (such as high blood pressure; hepatitis; gall bladder; gyn; pulmonary; arteriosclerosis, cancer, etc.; or other prolonged illnesses)

Do you take any medicines regularly? (prescriptions; aspirin/Tylenol/Advil; laxatives; hormones; "the pill")

Vitamins? (please indicate exactly)

Known allergies (medicines; pets; dust; pollen; lotions)

Have you ever had a transfusion?

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Indicate if any other these or similar conditions have been health problems.

Headaches
Vision change (blurring, spots; blind area)
Itchy eyes (dry eyes; allergic)
Dizziness (or fainting)
Poor memory
Runny nose, post nasal drip (sinus trouble)
Reduction/increase in sense of taste
Bloody nose
Dental problems (excessive cavities; gum disease)
Sore throats (excessive)
Difficulty swallowing
Thyroid problems (lumps; radiation therapy; low or high)
Enlarged glands
Cough
Shortness of breath (asthma; cardiac; pulmonary)
Coughing up blood:

Chest pains (tightness, pressure)
Enlarged heart
Palpitations (rapid or intense chest sensation)
Heart murmur (or clicks or prolapse)
High blood pressure
Breast changes (lumps, thickening)
Nausea/ Vomiting
Ulcers (gastritis; sensitive stomach; heartburn)
Abdominal pain
Colitis – irritable bowel

Excessive sweating
Moodiness/Depression/Anxiety

When was your last chest x-ray?
Electrocardiogram?
Blood count/urinalysis/rectal exam/proctoscope?
Physical exam?
(PneumoVax)
Chicken pox

Gas (belching; gas pains; flatulence)
Jaundice (or hepatitis)
Gall bladder problems
Constipation
Diarrhea
Bloody stool; black stool; mucus in the stool
Rectal pain
Rectal bleeding
Hemorrhoids
Kidney disease (stones; cysts; poor function)
Frequent urination
Painful urination
Gravel in urine
Sexually acquired disease
Herpes (oral; genital; "shingles")
Urinary tract infection (cystitis; bladder infection; urgency)
Joint or muscle pains (arthritis; bursitis; tendonitis)
Anemia (low blood; low iron)
Other blood disease (low platelets; polycythemia)
Sugar problems (diabetes; hypoglycemia)
Metabolism (slow; rapid; erratic; hot or cold feelings)
Poor circulation (varicose veins; hardened arteries)
Change in skin (moles, acne, psoriasis, acne
Fine lines in skin – wrinkles – rough skin
Skin discoloration -- red spots
Unwanted hair – small veins)
Change in hair texture or thickness
Fatigue (excessive)
Gain or loss of weight:
-over what time-
Alteration in, or unsatisfactory sexual function

Immunization: (please give dates)
Tetanus
Diphtheria

Measles, Mumps, Rubella
Pneumonia
Hepatitis

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WOMEN: At what age did your periods begin?
Do you/did you have excessive cramping?
When was your last period? What is the duration of your period?
What is the length of time between the beginning of one period and the beginning of the next?
When was your last Pap smear?
If you have had one, when was your last mammogram?
If you had children, did you breast feed?
How many times have you been pregnant?
Have you had vaginitis (irritation with or without itching)?
Have you had discharge?
Loss of libido (unusual lack of sexual interest)?
Any other GYN problem?

MEN: Have you had prostate problems (infections; slow urination; urinate too frequently)?
Loss of libido (unusual lack of sexual interest)?
Testicular changes (lumps; thickening; soreness)?
Discharge (even in the past)?
Burning urine?

FAMILY -

FATHER:
Present age, or age at death (please indicate)
State of health
Diabetes?
High blood pressure?
Kidney disease?
Heart attacks?
Stroke?
Blood disease?
Cancer?
Other illnesses (prostate, anemia)?

GRANDPARENTS:
Maternal grandmother:

Maternal grandfather:

Paternal grandmother:

Paternal grandfather:

MOTHER:

Present age, or age at death (please indicate)
State of health
Diabetes?
High blood pressure?
Kidney disease?
Heart attacks?
Stroke?
Blood diseases?
Cancer?
Other illnesses (fibroids; gall bladder; thyroid)?

BROTHERS AND SISTERS (including those diseased):
Ages
State of health
Other diseases

CHILDREN:

Ages
State of health
Other diseases

Other family members (notable conditions or diseases that "run in the family")

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DIET - PLEASE BE SPECIFIC (please try to indicate what you eat normally at each meal as well as in between)

Usual breakfast | Usual lunch | Usual dinner | Snacks

EXERCISE (What do you do and how often? If you have ceased, what did you do and when did you stop? If you are unable to exercise, what is your physical activity?)

SMOKING (including tobacco and other inhalants, what and how much do you/did you smoke? When did you start? If you stopped, when did you stop?)

LIQUOR - WINE (what sorts of alcohol and how much is your minimum/maximum and at what frequency?)

NONPRESCRIPTION DRUGS (please indicate the amounts, and if you have stopped, when did you stop?)

PROXY: If you were ever unable to make a medical decision such as having a test, or doing a procedure, or trying to decide if you should be given life support, who -- aside from the doctors -- would make such a decision?