Arthur Davidson, Jr., M.D.

Patient Application

(Please print or type)

Patient ID#		Private Physician Information:
Name:		Name:
Address:		Address:
Apartment #:		City/State:
City/State:		Zip Code:
Zip Code:		Phone #:
Home Phone #:		
Cell Phone #:		
Sex:	DOB:	

Marital Status:
□ Single
□ Married
□ Divorced
□ Widow

Health History:

Patient's Name:_____

Present Weight:_____ Minimum Adult Weight:_____ Age:_____

Height:_____ Maximum Adult Height:_____ Age:_____

Weight 1 yr. ago:_____ How many years overweight?_____

Weight 5 yrs ago:_____ Maximum Weight Loss_____

Previous weight reduction methods:

_____

_____

_____

Family History:

Has anyone in your family had any of the following: (Circle "GP" if Grandparent, "M" if mother, "F" if father, "S" if one or more siblings, and "C" if one or more children)

						COMMENTS:
Obesity	GP	M	F	S	C	_____
High Blood Pressure	GP	M	F	S	C	_____
High Cholesterol	GP	M	F	S	C	_____
Heart Disease	GP	M	F	S	C	_____
Stroke	GP	M	F	S	C	_____
Diabetes	GP	M	F	S	C	_____
Cancer	GP	M	F	S	C	_____
Gallbladder	GP	M	F	S	C	_____
Arthritis	GP	M	F	S	C	_____

Patient Past Medical History:

Have you had any of the following medical illnesses/events? If so, provide appropriate information.

Illness:	**Date of Onset:**	**Date of Hospitalization and/or Surgery:**	**Comments:**
Thyroid Disorder			
Tuberculosis			
Rheumatic Fever			
Heart Disease			
Hepatitis			
High Blood Pressure			
Kidney Disease			
Ulcer Disease			
Bowel Disease			
Anemia			
Psychiatric Conditions (e.g. depression, anxiety)			
Thrombophlebitis (Blood clots)			
Kidney Stones			
Diabetes			
Varicose Veins			
Sleep Apnea			
Gout			
Asthma			
Arthritis			
Gallstones			
Seizures/Convulsions			
Accidents/Injuries			
Full term live pregnancies			
Stillbirth pregnancies			
Miscarriages or Abortions			
Complications of pregnancy			
Substance/alcohol addiction			
Other			

Review of Systems (Circle Yes or No)

HEENT:			**COMMENTS:**
Frequent Headache	YES	NO	
Fainting	YES	NO	
Dizziness	YES	NO	
Loss of Hearing	YES	NO	
Change of Vision	YES	NO	
Dental trouble	YES	NO	
Bleeding or Swollen Gum	YES	NO	
Lumps on neck	YES	NO	
Glaucoma	YES	NO	
CARDIO-RESPIRATORY:			
Chest Pain/Pressure	YES	NO	
Rapid or irregular heart beat	YES	NO	
Shortness of breath	YES	NO	
Chronic cough	YES	NO	
Cough with sputum	YES	NO	
Swelling of legs and/or feet	YES	NO	
GASTRO-INTESTINAL:			
Indigestions or heartburn	YES	NO	
Nausea or vomiting	YES	NO	

Bowel Movements:

Average Frequency: Per Day:_____ Per Week:_____

Constipation:	YES	NO
Diarrhea	YES	NO
Abdominal cramps or bloating	YES	NO
Abdominal pain	YES	NO

URINARY **COMMENTS:**

Pain	YES	NO	
Blood	YES	NO	
Night-time frequency	YES	NO	
Incontinence (Poor bladder control)	YES	NO	

REPRODUCTIVE (Women Only)

Menstrual

Discharge	YES	NO	
Abnormal Cycle	YES	NO	
Abnormal Flow	YES	NO	
Excessive Complications	YES	NO	
Lumps on Breast	YES	NO	
Discharge from Nipple	YES	NO	
Have you ever had a mammogram?	YES	NO	
Date of last menstrual period_____			
Date of last gynecological exam_____			
Current birth control method (if applicable)_____			

REPRODUCTIVE (Men Only)

Impotence	YES	NO	

Musculo-Skeletal

Joint Pain	YES	NO	
Swelling of Joints	YES	NO	
Back Pain	YES	NO	
Leg Cramps	YES	NO	

Other

Daytime Sleepiness	YES	NO	
Difficulty Sleeping	YES	NO	
Hotter than usual	YES	NO	
Excessive Hair	YES	NO	
Loss of Hair	YES	NO	
Skin Texture, Changes/Problems?	YES	NO	

Physical Activity

Do you consider yourself an active person?	YES	NO	
Do you do physical activity on a regular basis?	YES	NO	

If yes, what type?_____

How many times per week?_____

Do you walk a mile or more a day?	YES	NO	

Psychological

Are you presently involved in individual or group counseling or therapy?	YES	NO	

Allergies			**If YES, Please Explain:**
Have you ever had a reaction to any of the following?			
Milk/Dairy Products	YES	NO	
Eggs or other food	YES	NO	
Vitamins	YES	NO	
Drugs or Medication	YES	NO	
Do you ever us the following?			**COMMENTS:**
Tobacco	YES	NO	
Alcohol	YES	NO	
Caffeine	YES	NO	
Current Medications:			
Blood pressure medication	YES	NO	
Birth control pills	YES	NO	
Cardiac medications	YES	NO	
Tranquilizers	YES	NO	
Antidepressants	YES	NO	
Pain medication	YES	NO	
Antacids	YES	NO	
Anti-coagulants (blood thinners)	YES	NO	
Weight loss medication	YES	NO	
Diabetes medication	YES	NO	
Gout medication	YES	NO	
Thyroid medication	YES	NO	
Stomach medication	YES	NO	
Antibiotics	YES	NO	
Laxatives	YES	NO	
Aspirin	YES	NO	
Iron supplements	YES	NO	
Calcium supplements	YES	NO	
Vitamins	YES	NO	
Other medication (include non-prescription items)	YES	NO	

Please list current medications and dosage including over the counter medications:

_____

_____

_____