VITA Medical Associates, P.C.

Anna A. Niewiarowska, M.D.

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PATIENT'S MEDICATION HISTORY FORM

MEDICATIONS:

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives and/or cold medications? Please circle YES or NO. If yes, please fill in below.

YES **NO**

Name of Medication	Dose	How often taken

ALLERGIES:

Have you had hives, skin rash, breathing problems, or other allergic reactions to medication?

NO **YES** (Please list meds below):

Name of Medication:	Describe Allergic Reaction:	Severity:

Have you ever had an allergic reaction to:

Latex or rubber No Yes **Iodine or x-ray dye** No Yes

Adhesive tape No Yes **Bee or wasp stings** No Yes

List any food allergies: _____

HEALTH SCREENING QUESTIONS:

Have you had the following?

Mammogram Yes No If yes, Date? _____ BY WHOM: _____

Pap Smear Yes No If yes, Date? _____ BY WHOM: _____

Colonoscopy Yes No If yes, Date? _____ BY WHOM: _____

Stool for Hemoccult Yes No If yes, Date? _____ BY WHOM: _____

Covid-19 Vaccine Yes No If yes, please provide dates:

1st Shot _____ 2nd Shot_____

Covid-19 Booster Yes No Date: _____

SMOKING HISTORY:

Do you use tobacco? (Please circle one) Yes No Cigarettes – pks/day _____ or pks/wk. _____

Chew - #/day_____ Pipe - #/day_____ Cigars - #/day_____ # of years_____

Vape – Yes No **Previous tobacco user** - year quit _____

REVIEW OF SYSTEMS

Please indicate whether you have experienced the following symptoms during the recent months by checking YES or NO for each. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question.

Blood Transfusions:

Have you ever had a blood transfusion? □ Yes □ No
If yes, did you have a reaction? □ Yes □ No
Date of Last Transfusion: _____

SKIN:

Skin rash, sore, excessive bruising, or change of a mole? □ Yes □ No

ENDOCRINE:

Excessive thirst or urination?
Change in sexual drive or performance? □ Yes □ No

NEUROLOGICAL/EYES, EARS, NOSE/THROAT:

Significant headaches, seizures, slurred speech or difficulty moving an arm or leg? □ Yes □ No
Eye problems such as double or blurred vision, cataracts or glaucoma □ Yes □ No
Diminished hearing, dizziness, hoarseness, or sinus problems? □ Yes □ No
Do you wear dentures? □ Yes □ No
If yes, please circle: Full Upper Lower Partial

RESPIRATORY/CARDIOVASCULAR:

Bothered with cough, shortness of breath, wheezing or asthma? □ Yes □ No
Coughing up sputum or blood? □ Yes □ No
Exposed to anyone with Covid-19 or tuberculosis? □ Yes □ No
"Blacked out" or lost consciousness? □ Yes □ No
Chest pain or pressure, rapid or irregular heartbeats or known difficulties with heart valve? □ Yes □ No

Awakening at night with shortness of breath?	□ Yes □ No
Abnormal swelling in the legs or feet?	□ Yes □ No
Pain in the calves of your legs when you walk?	□ Yes □ No

GASTROINTESTINAL:

Difficulty with swallowing, heartburn, nausea, vomiting, or stomach trouble?	□ Yes □ No
Significant problems with constipation, diarrhea, blood/ changes in bowel habits?	□ Yes □ No

GENITOURINARY:

Difficulty starting your urinary stream, completely emptying your bladder or leaking urine from your bladder?	□ Yes □ No
Burning or pain when urinating?	□ Yes □ No
Have you ever been exposed to Hepatitis?	□ Yes □ No
Have you ever been vaccinated for Hepatitis?	□ Yes □ No
Have you ever been treated for kidney stones?	□ Yes □ No
Have you ever been treated for a urinary tract infection?	□ Yes □ No

MUSCULOSKELETAL:

Pain, stiffness, or swelling in your back, joints or muscles?	□ Yes □ No

HEMATOLOGIC/INFECTIOUS DISEASE/LYMPHATIC:

Fever within the last month?	□ Yes □ No
Were you tested for Covid-19 infection?	□ Yes □ No
Did you test positive or negative? (Please circle one)	
Did you develop an illness secondary to Covid-19?	□ Yes □ No

If yes, please provide date and symptoms:

_____

GENERAL:

Experiencing an unusually stressful situation?	□ Yes □ No
Weight gain or loss of more than 10 pounds during the last six months?	□ Yes □ No
Problems falling asleep, staying asleep, sleep apnea or disruptive snoring?	□ Yes □ No
Abnormal nipple discharge or a breast lump?	□ Yes □ No
Have you ever felt a need to cut down on your alcohol consumption?	□ Yes □ No

Do relatives/friends worry or complain about your alcohol consumption? □ Yes □ No
Have you been physically, sexually, or emotionally abused? □ Yes □ No

OTHER MEDICAL PROBLEMS: If yes, please check

□ Hypertension □ Diabetes □ Other (Explain) _____
□ Heart Condition □ Phlebitis/Blood Clots □ None

FOR MALES ONLY:

Last PSA screening: _____ Last prostate exam date: _____

FOR FEMALES ONLY:

Age at First Menstrual Period _____

If still menstruating, date of last menstrual period _____

Age at Menopause _____

Have you ever taken birth control pills? □ Yes □ No How Long _____ Yrs

Do you now use birth control? □ Yes □ No Type _____

Have you ever taken fertility drug treatments? □ Yes □ No

Have you ever taken hormone replacements? □ Yes □ No How Long _____ Yrs

Are you currently taking hormone replacements? □ Yes □ No Type _____

Have you experienced menopause or had a hysterectomy? □ Yes □ No

If no: Are you concerned about your menstrual cycle? □ Yes □ No
Might you be pregnant at this time? □ Yes □ No

Number of Pregnancies: _____

Live Births: _____

Miscarriages/Abortions: _____

Did you breast feed? □ Yes □ No For how long _____

Do you have an Advanced Directive/Living Will? Yes_____ No_____

What are you current living arrangements: House Apartment Nursing Home Other _____

Do you live: (circle) Alone With spouse/family With others-Describe _____

Please list family or friends able to provide assistance with your homecare needs if you would ever require such assistance:

_____

_____

Do you use an ambulation device (Wheelchair, Walker, Cane)? No Yes If yes device used: _____

Past Medical History:

Please list any hospitalizations or surgeries including dates, illness and treatment:

Dates	Illnesses	Treatment

Family History:

Please list any pertinent family history that is significant (for example, any family history of heart disease, diabetes, cancer, etc.):
