Dr. David Zweiback
INTERNIST AND AESTHETIC PHYSICIAN
THE COMPLETE APPROACH TO A HEALTHY YOU

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BOARD CERTIFIED INTERNAL MEDICINE

Patient Name:______________________ DOB: __________ Occupation: ______________ Date:______________

Describe your main problem ____

Where is your problem located?______________________________________

How severe is your problem? ____

How long have you had this problem?__________________________________

When does this problem occur?______________________________________

Where were you when this problem started? ____________________________

What other things happen with this problem?____________________________

____

List previous hospitalizations/Surgeries/Serious Injuries/Illness When?

______________________________________ ______________

______________________________________ ______________

______________________________________ ______________

______________________________________ ______________

______________________________________ ______________

Patient Social History

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily ______________

Use of tobacco: ❑ Never ❑ Previously but quit ❑ Current packs per day ____

Use of Drugs: ❑ Never ❑ Type/Frequency______________________

Excessive exposure at home/work ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise ❑ Smoke

With whom do you live? ______________________________________

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	______________	______________
Mother	____	______________	______________
Siblings	____	______________	______________
	____	______________	______________
Spouse	____	______________	______________
Children	____	______________	______________
	____	______________	______________
	____	______________	______________
	____	______________	______________

Have you ever had the following?

Anemia..................	yes	no
Asthma..................	yes	no
Diabetes..................	yes	no
Hypertension............	yes	no
Cancer....................	yes	no
Stroke.....................	yes	no
Heart trouble............	yes	no
Arthritis/gout............	yes	no
Convulsions..............	yes	no
Bleeding tendency........	yes	no
Acute infections..........	yes	no
Venereal disease..........	yes	no
Hereditary defects.........	yes	no
Thyroid problems.........	yes	no
Kidney disease............	yes	no

List Medications you are currently taking

1)______________________

2)______________________

3)______________________

4)______________________

5)______________________

6)______________________

7)______________________

8)______________________

9)______________________

10)______________________

Family History

IF YES LIST RELATIONSHIP

Stroke	yes no	__________
Cancer	yes no	__________
Hypertension	yes no	__________
Diabetes	yes no	__________
Heart trouble	yes no	__________
Bleeding prob	yes no	__________
Asthma	yes no	__________
Anemia	yes no	__________
Convulsions	yes no	__________
Arthritis/gout	yes no	__________
Kidney disease	yes no	__________
Thyroid disease	yes no	__________
Hereditary defects	yes no	__________