SMITH CLINIC
ARTHUR L. KUMPF, M.D.
DEPARTMENT OF PLASTIC SURGERY
1040 DELAWARE AVENUE, MARION, OHIO 43302
740/375-6498 or 800/282-6741

New Patient Medical History

Name: _____ Today's Date: _____
Last First M.I.

Email:_____Permission to be added to email list? Y N

DOB: _____ **Name of primary care physician:** _____

Reason for visit? _____

_____

Medications (please list medication, dosage, and frequency):

_____

_____

_____

_____

Allergies (Drug and Reaction): _____

Social History (check all that apply):

□ Single □ Married □ Widowed □ Divorced

□ Children (Number_____)

□ Right Handed □ Left Handed

Current Job:_____ Prior Job:_____

Hobbies: _____

□ Smoke (Number of packs per day ___, Number of years____)

□ Quit (Date:_____) □ Never

□ Drink alcohol (Number of drinks per week ___) □ Quit (Date:_____) □ None

□ Other drugs _____

Family History (Please list any medical problems of your mother, father, brothers, or sisters):

_____

_____

_____

Any family history of bleeding disorders? □ Yes □ No

Past Medical History: **Medical Problems** (check all that apply)

□ High blood pressure □ Stroke □ Poor circulation

□ Diabetes □ Seizure □ Ulcers

□ Heart attack □ Hepatitis □ Asthma

□ Heart failure □ Bleeding disorder □ Kidney problems

□ Cancer (type:_____) □ Back pain □ Pneumonia

□ Others not listed above: _____

_____

Surgery (please list operations, dates, and surgeon)

_____

_____

_____

_____

Review of Systems

Eyes □ blindness □ visual changes □ cataracts □ glasses □ other_____

Ears □ buzzing/ringing □ sudden hearing loss □ other _____

Heart □ chest pain/tightness □ palpitations □ other_____

Lungs □ shortness of breath □ coughing up blood □ asthma □ wheezing □ other_____

Abdomen □ abdominal pain □ vomiting □ nausea □ heart burn □ diarrhea □ other_____

Neurological □ dizziness □ headaches □ stroke □ other _____

Constitutional □ fever □ chills □ weight loss □ night sweats □ loss of energy □ other _____

Psychiatric □ history of psych illness (Diagnosis:_____,

Admissions: _____)

Urinary □ blood in the urine □ cloudy urine □ pain during urination □ other _____

Musculoskeletal □ joint or muscle pain □ loss of sensation □ other_____

Skin □ rash or change □ other_____

Hematologic □ bleeding problem □ easy bruising □ bleeding from a dental procedure

□ other _____

Thank you for providing this important information.

_____ _____

Patient Signature Physician Signature

09/11