

Interval Data Sheet — Michael A. Freedman, D.O. Patient Name _____

Age _____ Height _____ Weight _____ Sex: M F Marital Status: S M D W L/W

If female, are or could you be **pregnant**? Y N Number of pregnancies _____

Allergies to Medications (If none, please indicate by writing NONE. List medication-reaction) _____

Current **Prescription Medications** _____

Herbal / Vitamins _____

History of **bleeding disorders** in you or your family? Yes No History of **transfusions**? Yes No

Current Medical Problems: Check any or all that apply, if not recent note approximate year beside item.

- | | | | | | |
|-------------------------------------------------------------|------------------------------------------------|-----------------------------------------------|--------------------------------------|---------------------------------------|----------------------------------------|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Irritable Bowel/Colitis | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sleep Apnea | | |
| <input type="checkbox"/> Recurrent Infections, where? _____ | | <input type="checkbox"/> Cancer, where? _____ | | | |

Medical conditions not listed? _____

Surgeries: Check any surgeries you have had, note approximate year (if known) beside item.

Location of Surgery

Specific Type of Surgery

- | | | | | |
|---------------------|-------------------------------------------|--------------------------------------------|-------------------------------------------------|-----------------------------------------|
| Ear Surgery | <input type="checkbox"/> Tubes | <input type="checkbox"/> Mastoidectomy | <input type="checkbox"/> Stapedectomy | <input type="checkbox"/> Ear-Unsure |
| Nose Surgery | <input type="checkbox"/> Septum | <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Sinus Surgery | <input type="checkbox"/> Nose-Unsure |
| Throat Surgery | <input type="checkbox"/> Tonsils | <input type="checkbox"/> Throat Cancer | <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Throat-Unsure |
| Neck Surgery | <input type="checkbox"/> Lymph Node | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Thyroglossal Duct Cyst | <input type="checkbox"/> Neck-Unsure |
| Breast/Lung Surgery | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Lung-Lobectomy |
| Heart Surgery | <input type="checkbox"/> Bypass | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Valve Replacement | <input type="checkbox"/> Heart-Unsure |
| Abdomen Surgery | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bowel Resection | <input type="checkbox"/> Splenectomy |
| Female Surgery | <input type="checkbox"/> D & C | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> C-Section |
| Eye Surgery | <input type="checkbox"/> Cataract | <input type="checkbox"/> Radial Keratotomy | <input type="checkbox"/> Laser | <input type="checkbox"/> Eye-Unsure |
| Other Surgery | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hip Fracture |

Surgery not listed _____

Complications of surgeries _____

Parents health (if deceased, cause of death) _____

Check all that apply to your **immediate family** (Parents, Siblings):

- | | | | | |
|--------------------------------------|----------------------------------------------|------------------------------------|---------------------------------|---------------------------------------------|
| <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Early Hearing Loss | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Problems |

Social History: (*Special note: Dr. Freedman is not judgmental regarding your habits, this information is essential to treating you and you can be assured it will NOT leave the chart---Please answer honestly*)

Tobacco use: Did you ever smoke cigarettes in your lifetime? Y N How much? Packs per day? _____ Years? _____

When did you quit smoking? _____ years ago. Do you use any other type of tobacco? pipe snuff

Alcohol use: Y N If yes, how often? rare monthly weekly daily How much? _____

Caffeine use: Y N Coffee Tea Pop Which one(s) and how much? _____

Recreational drug use: Y N If yes, what type and amount? _____

Sexual history: Any history of sexually transmitted diseases? Y N Have you been tested for **HIV**? Y N

Currently **working**? Y N Job Title: _____ Exposure to **chemicals**? _____

Exposure to **noise** at work? _____ Do you wear **hearing protection**? _____

If not currently working, are you on **disability**? Y N What type of injury? _____

I certify that the history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

I have reviewed the information on the two pages of the Introductory Data Sheet with the patient.

Michael A. Freedman, D.O. _____ Date _____