

SunState Medical Associates, P.A.

758 N. Sun Drive, Suite 104 • Lake Mary, FL 32746
(407) 333-3303 • Fax (407) 333-3342

FARIDEH A. ZADEH, M.D.
BOARD CERTIFIED INTERNAL MEDICINE

ZIA FATEMI, M.D.
BOARD CERTIFIED INTERNAL MEDICINE

POTHEN C. KORUTH, M.D.
BOARD CERTIFIED INTERNAL MEDICINE

REVIEW OF SYSTEM

NAME _____ AGE _____ TODAY'S DATE _____

EMPLOYER _____

DOCTORS you see now _____

DOCTORS you have seen in the past _____

CURRENT MEDICAL PROBLEMS _____

OTHER CONCERNS you would like to discuss with the doctor _____

LIST SURGERIES you have had (include year, surgeon, hospital) _____

Describe HOSPITALIZATIONS/ ILLNESSES not included above (include year, hospital) _____

List PRESCRIPTION MEDICINE you now take (include dosage, reason you take it, who prescribed it) _____

List OVER-THE-COUNTER MEDICINES, vitamins and food supplements you take _____

DRUG ALLERGIES _____ SENSITIVITIES _____

SOCIAL HISTORY

Tobacco Use? NO YES How many packs per day? _____ How many years? _____

Did you quit? NO YES If so, when? _____

Alcohol NO YES Amount per day? _____

Coffee, tea or cola? NO YES Amount per day? _____

Do you exercise regularly? NO YES How often? _____

What kind of work do you do? _____

Any toxic exposure? NO YES

What method of contraception do you use (if applicable) _____

- Have you had** (circle):
- | | | | |
|----------------------|---------------------|----------------------|---------------------|
| 1.) migraines | 2.) hepatitis | 3.) mono | 4.) ulcer |
| 5.) bleeding problem | 6.) blood clots | 7.) head injury | 8.) drug addiction |
| 10.) tuberculosis | 11.) STDs | 12.) seizures | 13.) memory trouble |
| 15.) psoriasis | 16.) heart murmur | 17.) rheumatic fever | 18.) polio |
| 20.) alcoholism | 21.) depression | 22.) mental illness | 23.) gout |
| 25.) hearing trouble | 26.) vision trouble | 27.) other _____ | 24.) hemorrhoids |

FEMALE PATIENTS-Do you have any problems with:

- | | | | | | |
|----------------------------|-----------------------------|------------------------------|----------------------------|-----------------------------|------------------------------|
| Cramps? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | Heavy Bleeding | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Irregular Periods | NO <input type="checkbox"/> | YES <input type="checkbox"/> | Discharge | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Painful Intercourse | NO <input type="checkbox"/> | YES <input type="checkbox"/> | Last Breast Exam/Mammogram | _____ | |
| Your last Menstrual Period | _____ | | Last Pap Smear | _____ | |

MALE PATIENTS-Do you have any problems with:

- | | | | | | |
|--------------------|-----------------------------|------------------------------|------------|-----------------------------|------------------------------|
| Penile Discomfort? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | Impotence? | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Other | _____ | | | | |

Do any of your family members have or have had:

- | | | |
|---------------------|-----------------------------|------------------------------|
| Cancer | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Heart attacks | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| High blood pressure | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Strokes | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Thyroid disease | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Diabetes | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Anemia | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Kidney disease | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Ulcers | NO <input type="checkbox"/> | YES <input type="checkbox"/> |
| Other | _____ | |

Family History:	Age	Illness
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
Sisters	_____	_____
Sons	_____	_____
Daughters	_____	_____
Other Relatives	_____	_____

When was your last:

- | | | |
|------------------------|--------------------------|-----------------------------|
| 1.) tetanus shot _____ | 2.) flu shot _____ | 3.) EKG _____ |
| 4.) TB test _____ | 5.) HIV test _____ | 6.) sigmoidoscopy _____ |
| 7.) chest x-ray _____ | 8.) pneumonia shot _____ | 9.) hepatitis vaccine _____ |
| 10.) rectal exam _____ | 11.) blood test _____ | |

Anything else? _____

Please Sign and Date: _____