Michael V. Stefanovich M.D.

Brief Health Information Form

Today's Date: _____

Your Name: _____

1. Describe any allergies you have:

To what?_____ Reaction you have_____

Allergy medications you take?_____

2. Do you currently have any medical problems? Have you had any medical problems in the past? Circle one:

Asthma	Current	Past	N	Diabetes	Current	Past	N
High Blood Pressure	Current	Past	N	Heart Disease	Current	Past	N
Cancer	Current	Past	N	**Other:**_____			

3. Have you done any kinds of work where you were exposed to toxic chemicals?

Date_____Kinds of chemicals?_____

Kind of work_____

Effects_____

4. Does anyone in your family suffer from psychiatric illness or see a psychiatrist?

_____

For women only

1. Menstrual period experiences:

How regular are they?_____How long do they last?_____

How much pain do you have?_____How heavy are your periods?_____

2. Menopause:

If your menopause has started, at what age did it start?_____

What signs or symptoms have you had?_____

_____