Jeffrey S.
Masin, MD

3085 W. Market St., Suite 102
Fairlawn, Ohio 44333
330-379-9070
fax 330-379-2358

Adult Health History (complete both pages)

Your name (please print) _____Today's date _____
Reason for seeing the Doctor _____
When did this problem begin _____

PAST MEDICAL HISTORY

Do you have any medical problems diagnosed by another doctor? ❑ Yes ❑ No
If yes, list them:_____

ALLERGIES

Are you allergic to any medications, grasses, pollens, foods, etc.? ❑ Yes ❑ No
If yes, please list:_____

MEDICATIONS

Are you taking any prescription or over-the-counter medications? ❑ Yes ❑ No If yes, list beginning with the most recent medication or ❑ SEE ATTACHED LIST

Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____

Have you ever been hospitalized? ❑ Yes ❑ No If yes, list beginning with the most recent:_____

_____

Have you had any surgeries or procedures? ❑ Yes ❑ No If yes, list beginning with the most recent:

_____

FAMILY HISTORY

Has anyone in your family had symptoms similar to those you are here for today?_____
Are your parents, brothers and sisters and children alive and well? ❑ Yes ❑ No If No, explain _____

_____

Has anyone in your family suffered from the following?

Asthma or Allergies	❑ Yes	❑ No	Cancer	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No	Heart Attack	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No

Explain Yes responses below (especially who they were and the age they were affected)

_____

_____

SOCIAL HISTORY

Describe your job and how long you have worked there_____
Are you a current smoker or tobacco user? ❑ Yes ❑ No How much do you smoke/use and for how long?

_____

If you are not a current tobacco user, have you ever smoked or used tobacco products? ❑ Yes ❑ No
Do you consume alcohol? ❑ Yes ❑ No If yes, how much and how often? _____

_____

(see next page)

Jeffrey S.
Masin, MD

3085 W. Market St., Suite 102
Fairlawn, Ohio 44333
330-379-9070
fax 330-379-2358

Review of Systems

Have you had any of the following symptoms recently? Explain all yes responses in the space next to the question.

Constitutional symptoms

Weight Loss ❑ Yes ❑ No _____
Weight Gain ❑ Yes ❑ No _____

Eyes

Frequent Pink Eye ❑ Yes ❑ No _____

Ears, Nose, Mouth, Throat

Ear Pain ❑ Yes ❑ No _____
Difficulty Swallowing ❑ Yes ❑ No _____
Painful Swallowing ❑ Yes ❑ No _____
Voice Change ❑ Yes ❑ No _____

Cardiovascular

Shortness of Breath ❑ Yes ❑ No _____

Respiratory

Cough ❑ Yes ❑ No _____
Snoring ❑ Yes ❑ No _____

Gastrointestinal

Stomach Aches ❑ Yes ❑ No _____

Musculoskeletal

Neck/back pain ❑ Yes ❑ No _____

Integumentary

Skin Rashes ❑ Yes ❑ No _____

Neurological

Headaches ❑ Yes ❑ No _____
Facial Weakness ❑ Yes ❑ No _____

Hematologic/Lymphatic

Easy Bruising ❑ Yes ❑ No _____
Bleeding problems ❑ Yes ❑ No _____

Allergic/Immunologic

Allergy Symptoms ❑ Yes ❑ No _____