

**Matthew J. Lynch, M.D.**  
**Patient History Form**

Name \_\_\_\_\_ Sex: Male/Female Age \_\_\_\_\_ Date \_\_\_\_\_

Type of Visit: \_\_\_New \_\_\_Follow-up \_\_\_Second Opinion \_\_\_ER Follow-up (Date in ER\_\_\_\_\_)

Have you seen any other Physicians for this problem? \_\_\_\_\_ if so name of doctor \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent loss \_\_\_\_\_lb Recent gain \_\_\_\_\_lb

**Past Medical History-Have you been treated for any of the following problems?**

___ Heart	___ Lungs	___ Liver	___ Kidney
___ Ulcers	___ Poor Circulation	___ Blood Pressure	___ Diabetes
___ Arthritis	___ Psoriasis	___ Cancer	___ Seizures
___ Stroke	___ Infections	___ Anemia	___ Bleeding disorders
___ Blood clots	___ Psychiatric	___ Hepatitis	___ HIV/AIDS
___ Thyroid Disease	___ Asthma	___ Depression	___ SLE/Lupus

**Name and Address of Primary Physician** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last Tetanus (Date) \_\_\_\_\_

Last Checkup(Date) \_\_\_\_\_

**Name of Referring Physician** \_\_\_\_\_

**Previous Surgery**

Operation	Year	Hospital /City	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any complications with surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain:

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**Medications** – Name, Dosage and Frequency

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Allergies** \_\_\_\_\_ Yes \_\_\_\_\_ No

Food \_\_\_\_\_

Reaction \_\_\_\_\_

Drug \_\_\_\_\_

Reaction \_\_\_\_\_

## Social History

Alcohol \_\_\_\_Heavy \_\_\_\_Moderate \_\_\_\_Social \_\_\_\_Occasional \_\_\_\_None

Coffee/Tea \_\_\_\_\_

Tobacco \_\_\_\_Yes \_\_\_\_No \_\_\_\_\_pks/day \_\_\_\_\_years

Illicit Drug use \_\_\_\_Yes \_\_\_\_No Type\_\_\_\_\_

Quit(when)\_\_\_\_\_

Has any member of your family reacted badly to being put to sleep for surgery? \_\_\_\_\_No \_\_\_\_Yes

Have you ever had a bad reaction to a local anesthetic? \_\_\_\_\_No \_\_\_\_Yes

Do you have an allergy to latex? \_\_\_\_\_No \_\_\_\_Yes

Are you presently on birth control pills? \_\_\_\_\_No \_\_\_\_Yes

Are you presently on hormonal replacement therapy? \_\_\_\_\_No \_\_\_\_Yes

Have you ever taken Accutane for treatment of acne? \_\_\_\_\_No \_\_\_\_Yes

Do you bleed or bruise easily ( from cuts, surgery, tooth extractions, shaving)? \_\_\_\_\_No \_\_\_\_Yes

Do you form large scars or keloids? \_\_\_\_\_No \_\_\_\_Yes

Have you ever taken steroids, cortisone, or ACTH? \_\_\_\_\_No \_\_\_\_Yes

Do you have shortness of breath with walking? \_\_\_\_\_No \_\_\_\_Yes

Do you have or have you had any back troubles? \_\_\_\_\_No \_\_\_\_Yes

Does your religion prohibit blood transfusions? \_\_\_\_\_No \_\_\_\_Yes

Do you have or have you ever had any significant emotional problems? \_\_\_\_\_No \_\_\_\_Yes

Have you ever had, or been advised to seek psychiatric care? \_\_\_\_\_No \_\_\_\_Yes

Are you currently pregnant? \_\_\_\_\_No \_\_\_\_Yes

Do you take Aspirin or Aspirin products(Ibuprofen, Motrin, Aleve etc...)? \_\_\_\_\_No \_\_\_\_Yes