

GREGORY NESTOR. M.D.

DEBORAH NOLAN; APRN-C, MSN

Name _____ Age _____ DOB _____ SINGLE _____ MARRIED _____
DIVORCED _____ WIDOW _____

Address: _____ Phone: _____

Next of kin: _____ Phone: _____

Next of kin address: _____

Occupation: _____ Referred by: _____

What medical doctor did you see last? _____ When: _____

1. What childhood illnesses have you had? _____

2. Did you have any unusual or severe illnesses prior to age 18 _____

3. Give the year or your age if you have had any of the following operations:

Tonsillectomy _____	Hysterectomy _____	Ear Operation _____
Gall Bladder Operation _____	Vein operation _____	Hernia _____
Stomach Operation _____	Appendectomy _____	Artery Operation _____
C-Section _____	Hemorrhoidectomy _____	Heart _____
Breast Surgery _____	Lung Operation _____	Other _____
Prostate Operation _____	Eye Operation _____	Cataract Operation _____

4. If you have any of the following problems, please mark with an "X" :

Diabetes _____	High blood pressure _____	Prostate problems _____
Anemia _____	Heart trouble _____	Lung trouble _____
Cancer _____	Kidney/bladder trouble _____	Stomach/bowel trouble _____
Arthritis _____	Female problems _____	Depression _____
Thyroid problems _____		

5. If you have had any broken bones, whether right or left, and the year in which the injury occurred:

6. Give the years and reason if you have been hospitalized for anything besides injuries or operations:

7. Except as noted above, for what have you been treated by physicians during the past 10 years other than common colds:

8. What medicines do you now take and how often do you take them:

9. Have you ever had a blood transfusion? _____ When? _____ How many? _____

10. List any medications to which you are allergic: _____

Have you ever had asthma or hay fever? _____

11. Women Only : At what age did your periods commence? _____
 At what age did they stop? _____
 What if any trouble do you have with your periods? _____

 How many living children have you had? _____ How many still births? _____
 How many miscarriages? _____

12. Occupation _____ Are you retired? _____
 What is your spouses age? _____
 Do you consider him/her to be in good health? _____
 If not, why? _____
 In what year were you married? _____
 How many alcoholic drinks do you consume in an average week? _____
 How many pipes, cigars, packs of cigarettes do you smoker per day, on average? _____
 If you quit smoking, when did you stop? _____
 How many cups of coffee do you drink per day? _____ Tea? _____
 What state were you born? _____
 If foreign born, at what age did you come to this country? _____
 Do you generally sleep well? _____
 What are your principal hobbies or recreational activities? _____
 If you were in the Armed Services, what branch and years? _____

Living

Deceased

	Age	State of health	Chronic Diseases	Age at death	Cause of death	Other illnesses
Father						
Mother						
Brothers						
Sisters						
Children						

Except as noted, have any close blood relatives had cancer?

High blood pressure?

Diabetes? _____ Tuberculosis _____

Any disease that run in the family? _____

HOSPITAL DATA:

admission Date: _____ Admission diagnosis: _____

Lab data: _____