GREGORY NESTOR, M.D. *DEBORAH NOLAN, A.R.N.P.*

NAME_____ AGE_____ SEX_____ S M W D_____

ADDRESS_____ PHONE_____ DATE_____

NEXT OF KIN_____ ADDRESS_____

OCCUPATION_____ REFERRED BY_____

MEDICARE OR OTHER INSURANCE I.D.#_____ D.O.B._____

WHAT MEDICAL DOCTOR DID YOU LAST SEE?_____ 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_____
Cataract Operation_____	Prostate Operation_____	Lung Operation_____
Gall Bladder Removal_____	Vein Operation_____	Hernia_____
Stomach Operation_____	Appendectomy_____	Artery Operation_____
C-Section_____	Eye Operation_____	Heart_____
Breast Surgery_____	Hemorrhoidectory_____	Others_____

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 or Bladder Trouble_____	Stomach or Bowel
Arthritis_____	Female Problems_____	Trouble_____
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 operation:_____

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

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 medicines to which you are allergic: _____
Have you ever had asthma or hay fever? _____

(OVER)

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. a. Occupation _____ Are you retired?_____
b. What is your spouse's age?_____
c. Do you consider him/her to be in good health? _____ If not, why not? _____
_____
d. In what year were you married? _____ How many beers, shots, cocktails and highballs do you consume in an average week?_____
e. How many pipes, cigars, or packs of cigarettes do you smoke per day, on the average?_____
_____
f. How many cups of coffee do you drink per day?_____ Tea _____
g. In what state were you born?_____ If foreign born, at what age did you come to this country? _____ In what state did you live most of your life?_____
h. Do you generally sleep well?_____
i. What are your principal hobbies or recreational activities?_____
j. If you were in the Armed Services, what branch and years? _____

13.

	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:_____
_____
_____