JOHN J. BORKOWSKI, MD
PATIENT MEDICAL INFORMATION
(Confidential)

Today's Date: _____

Name: _____
Last First Mi

Height _____ Weight _____Date of Birth_____

Medications: List all prescription, over the counter, and herbal medications

Name	Dose	How Often/Frequency	Route/How taken

Allergies: List all allergies including medications, food, iodine, etc.

Medical Conditions/Problems:_ Check all that apply

	Heart Attack		Asthma		Bleeding disorder		Cancer
	Heart Murmur		COPD		Blood Clots		Diabetes
	Stents		Pneumonia		Anemia		Arthritis
	Aneurysm		Bronchitis		Easy Bruising		Glaucoma
	Angina		Tuberculosis		Phlebitis		Kidney Stones
	Pace maker		Emphysema		Varicose Veins		Bladder Problems
	Defibrillator		Trouble Breathing		Ulcer		Cirrhosis Liver
	Stroke		Pulmonary Embolism		GERD		Hepatitis A, B, C

	High Blood Pressure		Sleep Apnea		Diverticulitis		Aids, Positive HIV Test

Any Conditions Not Listed Above:

_____

_____

_____

List all Previous Operations:

Name of operation	Date (Include month and year)

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Today's Date: _____

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List any hospitalizations not related to above operations

Reason for hospitalization	Date: include month and year

Significant Family History: (List condition and relative)

Condition	Relative

Social History:

Do you Smoke? Yes No If yes, how many Cigarettes or Packs per day _____
(Circle one)

Do you drink Alcohol? Yes No If yes, how many drinks per day _____ per week _____

Marijuana use Yes No How much per day_____or week_____

Drug use? Yes No _____

Do You Have An Advanced Directive (DNR Do Not Resuscitate)? Yes_____ No_____