Peter J. Lydon, M.D., F.A.C.S.
825 Washington Street, Suite 220, Norwood, MA 02062.
(781) 762-2600 | www.DrPeterLydon.com

(To help your doctor better treat you, please complete all items as completely as possible)

Name:______________________________ Date of Birth:__________ Age:_______ Height:________ Weight:__________

1. What is the reason for your visit today?____
2. How long have you had this problem?____
3. Did someone you know or a Doctor refer you? If so, please write his/her name. _________________________________
4. Did you hear about us another way? Circle all that apply. Dr. Lydon's Website Facebook Brochure Vitals/Healthgrades
5. Who is your Primary Care Doctor?______________________________

Past Medical History

Y	N		Y	N		Y	N	
☐	☐	Heart Disease / Attack	☐	☐	Seasonal Allergies	☐	☐	Seizures
☐	☐	High Blood Pressure	☐	☐	Migraine Headache	☐	☐	Mental Illness / Depression
☐	☐	Diabetes	☐	☐	Arthritis	☐	☐	Life-threatening reaction to anesthesia
☐	☐	Stroke	☐	☐	Bleeding Problems	☐	☐	Cancer (specify location & treatment)
☐	☐	Emphysema / Bronchitis	☐	☐	Thyroid Disease			
☐	☐	Asthma	☐	☐	Glaucoma			
☐	☐	High Cholesterol	☐	☐	Acid Reflux (GERD)			

Past Surgical/Hospitalization History (List any operations & all hospitalizations)

1. _________________________________ Date________ 4. ___________________________________ Date________
2. _________________________________ Date________ 5. ___________________________________ Date________
3. _________________________________ Date________ 6. ___________________________________ Date________

Medications (include over-the-counter non-prescription medications, vitamins, herbal supplements)

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Allergies to Medications? List below or check this box: ☐ No known medication / drug allergies

Medication: _____________________________ Reaction: ☐ Rash ☐ Hives ☐ Anaphylaxis ☐ Diarrhea ☐ Other:
Medication: _____________________________ Reaction: ☐ Rash ☐ Hives ☐ Anaphylaxis ☐ Diarrhea ☐ Other:
*Latex Allergy? ☐ Yes ☐ No

Social History

1. Occupation ____ 2. Marital Status_______________________
3. Do you Smoke? ☐ No ☐ Yes:_______packs/day for _______ years OR ☐ I used to smoke but quit _____ years ago
4. Alcohol consumption: _______ drinks/day or ________ drinks/week 5. Coffee: _________ cups/day

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Review of Systems: Do you have any of the following? (please check a box for each item)

Y	N		Y	N		Y	N	
☐	☐	Chest pain / angina	☐	☐	Heartburn	☐	☐	Memory loss
☐	☐	Heart murmur	☐	☐	Diarrhea or Constipation	☐	☐	Migraine headaches
☐	☐	Swelling of the legs / ankles	☐	☐	Blood in the stool	☐	☐	Mood disorder
☐	☐	Shortness of breath	☐	☐	Liver failure	☐	☐	Visual loss
☐	☐	Chronic cough	☐	☐	Easy bruising / bleeding	☐	☐	Skin condition
☐	☐	Coughing or spitting up blood	☐	☐	Kidney failure	☐	☐	Weight loss: ___ lbs in ____ months
☐	☐	Thyroid problem	☐	☐	Urinary tract infection	☐	☐	Weight gain:____lbs in ____months

Family History- blood relatives only (please check a box for each item)

Y	N		Y	N		Y	N	
☐	☐	Throat or Voice box cancer	☐	☐	Bleeding disorder	☐	☐	Migraine headaches
☐	☐	Thyroid cancer	☐	☐	Allergic reaction to anesthesia	☐	☐	Alcoholism
☐	☐	Hearing aide use in childhood	☐	☐	Hay fever/allergies	☐	☐	Cancer (specify) _______________
☐	☐	Hearing loss in adulthood	☐	☐	Heart disease or stroke	☐	☐	Other:

Patient Signature:________________________________ Date:___________________