

Medical History

Please check "Yes" or "No" to indicate if you have had any of the following problems:

Yes	No	Nature of Problem	Comments & Give Approximate Date
		Are You Allergic to Any Medication? If "Yes" List:	
		Are You Diabetic?	
		Are You on Insulin?	
		Do You Take Oral Diabetic Medicine?	
		Who is Your Doctor for Diabetes?	
		Recent Unexplained Weight Loss?	
		Headaches	
		Do You wear Glasses/Contacts?	
		Trouble with Hearing?	
		Hay Fever	
		Asthma	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse	
		Heart Murmur	
		Poor Circulation	
		High Blood Pressure	
		Chest Pain	
		Do You Have a History of Tuberculosis?	
		Do You Have a History of Pneumonia?	
		Do You Easily get Short of Breath?	
		Liver Disease or Jaundice	
		Gall Bladder Disease	
		Thyroid	

Are you on any current medications? Yes No (circle one)
 If yes, complete medication sheet.

PLEASE COMPLETE THE REVERSE SIDE-THANK YOU!!

Yes	No	Nature of Problem	Comments & Give Approximate Date
		Stomach Trouble	
		Do Anti-inflammatory Medicines or Aspirin Upset Your Stomach?	
		Swelling in Feet or Ankles	
		Arthritis	
		Kidney Disease or Stones	
		Gout	
		Bleeding Tendency	
		Scarring Tendency	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Cramps in Feet or Legs	
		Low Back Pain	
		Do You Smoke? Packs per Day	
		Do You Drink Alcohol? Drinks (oz) per Week	
		Prior Surgeries List	
		Depression/ Anxiety	
		Fainting or Convulsions	
		Strokes	
		High Cholesterol	
		Other Illnesses or Problems	
		HIV Positive	

Indicate by each of the following if your mother, father, grandparents or siblings have had any of the following diseases:

Cancer _____ Diabetes _____
 Heart Trouble _____ High Blood Pressure _____
 Kidney Disease _____ Mental/Emotional Disease _____
 Stroke _____ Arthritis _____

What problems bring you to our office? _____

Patient Signature _____ Date _____