NAME: _____ Date: _____

Please answer the following questions about your Medical History (Please circle your answers)

1. PAST MEDICAL HISTORY

4. Do You have any of the following Medical Disorders?

Heart Problems: Yes No
High Blood Pressure: Yes No
Diabetes: Yes No
Hepatitis: Yes No
Indigestion, Heartburn or Ulcers: Yes No
Mental or Emotional Problems: Yes No

Lung Diseases: Yes No
Epilepsy: Yes No
Cancer: Yes No
Kidney Disease: Yes No
Tuberculosis: Yes No

4. Have you had any surgery? Yes No
If YES, please provide date and reason: _____

C) Have you ever been hospitalized? Yes No
If YES, please provide date and reason: _____
_____

D) Do you take any medications for allergy or asthma? Yes No
If YES, please list: _____
Do you take any other medications? Yes No
If YES, please list: _____

E) Do you have any drug or food allergies: Yes No
If YES, please list: _____

2. REVIEW OF SYSTEMS

Do you currently have any of the following problems:	YES	NO	If YES, please explain
Chronic fever, unexplained weight loss/gain, fatigue	____	____	_____
Eye problems (e.g. Cataracts, glaucoma)	____	____	_____
Ear/Nose/Throat (e.g., hearing loss, sinus problem or sore throat)	____	____	_____
Respiratory problems (e.g., shortness of breath, wheezing, cough)	____	____	_____
GI problems (e.g., heartburn, abdominal pain, diarrhea)	____	____	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	____	____	_____
Skin problems (e.g., rashes, excessive dryness)	____	____	_____
Musculoskeletal problems (e.g., muscle aches, joint pain)	____	____	_____
Neurological problems (e.g., numbness, weakness, headaches)	____	____	_____
Psychiatric problems (e.g., depression, anxiety)	____	____	_____

3. FAMILY and SOCIAL HISTORY

Do any medical diseases run in your family (e.g., diabetes, high blood pressure, allergy, asthma, cancer, glaucoma, etc.)? Yes No If YES, please list: _____
_____

Do you smoke? Yes No If YES, how many packs a day? _____

4. COMMENTS:

M.D. Signature: _____ Date: _____