MEDICAL HISTORY

PATIENT NAME: _____

How is your general health? ___Excellent ___Good ___Fair ___Poor
Have you seen a physician during the last year: ___Yes ___No
If Yes, for what reason? _____
Are you presently under his care? _____
Do you smoke? ___Yes ___No How much? _____ For how long? _____
If you quit, when? _____
Do you drink? ___Yes ___No How many drinks per day? _____
Do you have any known allergies? _____ Please list: _____

Females: Are you pregnant? ___Yes ___No If Yes, how many months? _____

Please check and give dates if you HAVE OR HAVE HAD any of the following:

_____ Diabetes
_____ Rheumatic Fever
_____ High Blood Pressure
_____ Shortness of Breath
_____ Asthma
_____ Stomach Trouble
_____ Epilepsy
_____ Skin Disorders
_____ Liver Disorder
_____ Tuberculosis
_____ Heart Trouble
_____ Kidney or bladder disorder
_____ Vascular Problem (hardening of arteries, etc.)
_____ Varicose Veins or inflamed veins (Phlebitis)
_____ Conditions not listed _____

_____ Bleeding Tendencies
_____ Difficulty Healing
_____ Tumors
_____ Glaucoma
_____ Gout
_____ Bursitis
_____ Stroke
_____ Venereal Disease
_____ Blood Disease
_____ Anemia
_____ Cancer
_____ Arthritis or "Rheumatism"
_____ Foot Ulcers

Family History: (Parents, Brothers, Sisters and/or Children)

_____ Diabetes
_____ Heart Disease
_____ Anemia

_____ High Blood Pressure
_____ Cancer
_____ Other

Father:
Age____ Alive____ Deceased____

Mother:
Age____ Alive____ Deceased____

Current Medications, Dosages:

_____
_____
_____
_____

_____
_____
_____
_____

Please include any information not requested that YOU FEEL IMPORTANT on the reverse side (Example: Surgeries, etc.)