MEDICAL HISTORY

PATIENT NAME: ____ DOB: _____________________

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 their care? ____

Do you smoke? ______ Yes ______ No How much? ______ For how long? ______

If you quit, when? ____

If 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	__________	Bleeding Tendencies
__________	Rheumatic Fever	__________	Difficulty Healing
__________	High Blood Pressure	__________	Tumors
__________	Shortness of Breath	__________	Glaucoma
__________	Asthma	__________	Gout
__________	Stomach Trouble	__________	Bursitis
__________	Epilepsy	__________	Stroke
__________	Skin Disorders	__________	Venereal Disease
__________	Liver Disorders	__________	Blood Disease
__________	Tuberculosis	__________	Anemia
__________	Heart Trouble	__________	Cancer
__________	Kidney or Bladder disorder	__________	Arthritis or “Rheumatism”
__________	Vascular Problem (hardening of arteries, etc.)	__________	Foot Ulcers
__________	Varicose Veins or Inflamed veins (phlebitis)		
__________	Condition not listed- ____		

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

__________	Diabetes	__________	High Blood Pressure
__________	Heart Disease	__________	Cancer
__________	Anemia	__________	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 (Examples: Surgeries, etc.)