Medical / Past Medical History Form

Are you under a physician's care now? Yes or No If yes, who

_____

Are you taking any medications, pills or drugs? Yes or No

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications or have any allergies? Yes or No

_____ _____

_____ _____

_____ _____

Do you use tobacco? Yes or No If yes, How many years _____ Packs per day_____

Do you drink? Yes or No If yes, How much?_____

Do you use controlled substances? Yes or No If yes, which substances

_____ _____

_____ _____

What surgeries or procedures have you had? Surgery and Year

_____ _____

_____ _____

_____ _____

_____ _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes or No	Alzheimer's Disease	Yes or No
Allergies	Yes or No	Anaphylaxis	Yes or No
Anemia	Yes or No	Anxiety	Yes or No
Arthritis	Yes or No	Asthma	Yes or No
Blood Diseases	Yes or No	Blood Transfusion	Yes or No
Breathing Problems	Yes or No	Cancer	Yes or No
Chemotherapy	Yes or No	Chest Pains	Yes or No
Convulsions	Yes or No	Diabetes	Yes or No
Drug Addiction	Yes or No	Emphysema	Yes or No
Epilepsy or Seizures	Yes or No	Excessive Bleeding	Yes or No
Excessive Thirst	Yes or No	Fainting Spells/Dizziness	Yes or No
Frequent Cough	Yes or No	Frequent Diarrhea	Yes or No
Frequent Headaches	Yes or No	Genital Herpes	Yes or No
Glaucoma	Yes or No	Hay Fever	Yes or No
Heart Attack/Failure	Yes or No	Heart Murmur	Yes or No
Heart Pacemaker	Yes or No	Heart Trouble/Disease	Yes or No
Hepatitis A	Yes or No	Hepatitis B	Yes or No
Hepatitis C	Yes or No	High Blood Pressure	Yes or No
High Cholesterol	Yes or No	Kidney Problems	Yes or No
Leukemia	Yes or No	Liver Disease	Yes or No
Mitral Valve Prolapse	Yes or No	Osteoporosis	Yes or No
Psychiatric Care	Yes or No	Radiation Treatments	Yes or No
Renal Dialysis	Yes or No	Shingles	Yes or No
Sickle Cell Disease	Yes or No	Stroke	Yes or No
Thyroidism	Yes or No	Ulcers	Yes or No
VenerealDisease/STD	Yes or no	Yellow Jaundice	Yes or No

Others:

What medical conditions run in your Family? Also state who had the disease:

_____ _____

_____ _____

_____ _____

_____ _____

What do you do for a living?_____

How would you rate your stress level? Low/Medium/High.

If you are stressed out, why?_____

_____

What's your activity level? Low/Medium/High

How do you sleep? Good/Fair/Poor

Are you sexually active?_____

How many children do you have?_____

Do you suffer from vaginal dryness? _____

Do you suffer from difficulty urinating/incontinence?_____

Last mammogram?_____

Last Colonoscopy?_____

Last Pap Smear?_____

Tetanus Vaccine_____

Pneumonia Vaccine_____

If you smoke, have you ever had an abdominal Ultrasound to screen for Aortic Aneurysm

What's the reason for your visit?

_____

_____

_____

_____

What are you looking for in a doctor?

_____
_____
_____
_____

How did you hear about us?

_____