

Medical History

Name: _____ Height: _____ Weight: _____ Shoe Size: _____

Family Doctor: _____ Ph No _____ Date Last Seen _____

Diabetic Doctor: _____ Heart Doctor: _____

Pharmacy Name: _____ Ph No _____

Describe the condition that brought you to our office, including the location and duration of the problem:

Please check YES if any of the following pertain to you:

YES	CHEST	EXPLANATION	YES	MUSCULO-SKELETAL/NEURO	EXPLANATION
	Bronchitis,Chronic cough			Arthritis	
	Asthma/Emphysema,COPD			Back pain or injury	Where?
	Tuberculosis			Slipped disk,Sciatica	
	Tobacco Use? Yr Quit____or	Packs/per day_____		Epilepsy,seizures	
	GASTROINTESTINAL			Stroke,TIA	
	Jaundice,Hepatitis,Cirrhosis			Polio,paralysis	
	Hiatal Hernia/Heartburn			Psychiatric Care	
	Alcohol?	How often? _____		Numbness, tingling	
	What kind? _____	How many? _____		ENDOCRINE/MISC	
	CARDIOVASCULAR			Thyroid condition	
	High/Low Blood Pressure			Diabetes, How long? _____	Diet, Pills, Insulin(ck one)
	Chest pain/Angina			Elevated Cholesterol	
	Irregular heartbeat/murmur			Bleeding Disorder/Anemia	
	Heart Attack/Heart Problems?			Unusual reaction to anesthesia	
	Mitral valve disease			Cancer anywhere	
	HEAD/NECK/SKIN			HIV	
	Impaired Hearing/vision			OTHER ILLNESSES	
	Scar Formation				

1. LIST ANY SURGERIES:

2. LIST ALL MEDICATIONS:(or bring a list)

3. ALLERGIES: _____

4. DO YOU HAVE HOME HEALTH OR HOSPICE COMING TO YOUR HOME? YES NO

FAMILY HISTORY:

MOTHER: ALIVE? YES NO IF NO, CAUSE OF DEATH: _____

FATHER: ALIVE? YES NO IF NO, CAUSE OF DEATH: _____

DO ANY BLOOD RELATIVES SUFFER FROM?

___Diabetes ___Heart Disease ___Cancer ___Bleeding Tendencies ___Other _____

Which relatives? _____

Additional Comments: _____

Office Use:

VITALS BP _____ **PULSE** _____ **RESPIRATIONS** _____