MEDICAL HISTORY

Date: _____

Name:_____ **Day Phone** _____

Eve Phone_____

Current Medical History:

What symptoms are you experiencing?

_____

_____

_____

_____

Have you ever had similar problems? Yes_____ No_____

Past Medical History and Review of Systems:

Please check if you have or were treated for any of these problems

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest Pain/ Tightness
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations
- ☐ Urinary Difficulty
- ☐ High Cholesterol
- ☐ Dizziness
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent Cough
- ☐ Hay Fever
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Asthma
- ☐ Ulcers
- ☐ Gall Bladder Dis.
- ☐ Thyroid Problem
- ☐ Arthritis
- ☐ Anemia
- ☐ Anxiety
- ☐ Depression
- ☐ Gout
- ☐ Weight Loss

Are you taking any medications? Yes_____ No_____

If Yes, List: 1._____ 2._____

3._____ 4._____

5._____ 6._____

Are you allergic to any medications or x-ray dyes? Yes_____ No_____

If Yes, List: 1._____ 2._____

3._____ 4._____

Do you drink alcoholic beverages? Yes_____ No_____

Do you smoke? Yes_____ No_____

Have you had any Surgery? Yes_____ No_____

If Yes, List:

_____

_____

_____

_____

Date of last Physical/ Pap Smear:_____