PERSONAL MEDICAL HISTORY

NAME: ______________________ **AGE:** ____________

REASON FOR VISIT: ______________________

Do you have or have you ever had any of the following medical problems:

YES	NO	**Cardiovascular**
___	___	High Blood Pressure
___	___	Coronary Artery Disease
		Stent - Angioplasty - Heart Bypass (circle)
___	___	Heart Attack
___	___	Congestive Heart Failure
___	___	Irregular Heart Rhythm
___	___	Pacemaker or Defibrillator
___	___	Aneurysm - Where? ____________
___	___	Peripheral Vascular Disease
___	___	Blood Clot - Where? ____________
___	___	Pulmonary Embolus
___	___	Varicose Veins
___	___	Spider Veins
___	___	Phlebitis
___	___	High Cholesterol
___	___	Other - List:____________
		Pulmonary
___	___	Asthma
___	___	Chronic Bronchitis
___	___	Emphysema
___	___	Lung Cancer
___	___	Pneumonia
___	___	Other - List: ____________
		Neurological
___	___	Stroke
___	___	TIA (mini-stroke)
___	___	Migraine Headaches
___	___	Seizures
___	___	Brain Tumor
___	___	Other - List: ____________
		Gastrointestinal
___	___	Acid Reflux (GERD)
___	___	Ulcers
___	___	Gallbladder Disease
___	___	Liver Disease / Hepatitis
___	___	Hernia
___	___	Irritable Bowel Syndrome (IBS)
___	___	Hemorrhoids
___	___	Other - List: ____________
		Skin
___	___	Skin Ulcers - Where? ____________
___	___	Dermatitis
___	___	Skin Cancer
___	___	Other - List ____________

YES	NO	**General**
___	___	Weight Changes
___	___	Change in appetite
___	___	Sleeping problems
___	___	Excessive thirst
___	___	Fevers
___	___	Chills
___	___	Night sweats
		Reproductive (female)
___	___	Menopause (at what age did you periods cease?) ____________
___	___	Are you using birth control?
___	___	Yeast infections?
		Genitourinary
___	___	Kidney Failure
___	___	Are you on dialysis? Type hemo / peritoneal
___	___	Kidney Stones
___	___	Incontinence
___	___	Enlarged Prostate
___	___	Other - List: ____________
		Endocrine/Other
___	___	Cancer - Type: ____________
		Treatment: ____________
___	___	Diabetes - Type 1 / Type 2
___	___	Thyroid Disease
___	___	Lupus
___	___	HIV/AIDS
___	___	Other - List: ____________
		Psychiatric
___	___	Depression
___	___	Anxiety
___	___	Other - List: ____________
		Musculoskeletal
___	___	Back Problems
___	___	Neck Problems
___	___	Arthritis
___	___	Gout
___	___	Osteoporosis
___	___	Treatment for chronic pain?
___	___	Other - List: ____________
		Head/Neck/ENT/Eyes
___	___	Hard of Hearing
___	___	Cataracts
___	___	Glaucoma
___	___	Legally Blind
___	___	Other - List: ____________

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES/NO

List name(s) and reaction(s):

SURGICAL HISTORY

DATE	DESCRIPTION	HOSPITAL AND SURGEON

CURRENT HEIGHT: ________ **WEIGHT:** ________