PATIENT MEDICAL HISTORY

Please circle any of the following conditions that you have or had:

- Acne
- Anemia
- Ankle Swelling
- Anxiety
- Arthritis
- Artificial joint replacement
- Asthma
- Autoimmune dz (HIV/AIDS)
- Basal Cell Carcinoma
- Bleeding Disorders
- Cancer
- Cataracts
- Charcot foot
- Chemical Dependency
- Chest Pain
- Circulatory Disorders
- COPD
- CRPS/RSD
- Depression
- Diabetes
- Epilepsy
- Fibromyalgia
- GI Bleeding
- GI reflux/GERD
- Gout
- Heart Attack
- Heart Disease
- Hepatitis A B C D E
- Hernia
- High Blood Pressure
- High Cholesterol
- Hyperthyroid
- Hypothyroid
- Kidney Disease
- Liver Disease
- Malignant Melanoma
- Mitral Valve Prolapse
- Muscular Dystrophy
- Pulmonary Fibrosis
- Raynaud's
- Rheumatoid Arthritis
- Seizures
- Shortness of Breath
- Squamous Cell Carcinoma
- Stroke
- Tuberculosis
- Warts
- Other:

ARE YOU DIABETIC? YES ___ NO ___ IF YES, LAST GLUCOSE READING _______ A1c _______

PAST SURGICAL HISTORY - please list procedure & date


FAMILY MEDICAL HISTORY

Mother Alive? Yes ___ No ___ Past/Med Hx ______
Father Alive? Yes ___ No ___ Past/Med Hx ______
# of Brothers _______ PMH ______
# of Sisters _______ PMH ______

SOCIAL HISTORY - please circle one

Single. Married (____ years). Widowed. Separated. Divorced. # of Healthy Children____ # of Deceased Children____


Weight Lifting. Other ______

Caffeine: YES ___ NO ___ Alcohol: YES ___ NO ___ If Yes, Daily or Occasionally.

Do you follow any special diet: YES ___ NO ___ If Yes, Why ______

Sleep Habits: Unremarkable. Patient has: Trouble Falling Asleep, Trouble Staying Asleep, Frequent Nighttime Urination, Daytime Drowsiness, Nightmares, and Restless Legs.

Height _____ ft _____ in. Weight _____ lbs. Shoe Size _______

Current Medications and Doses (If Known) _______

Pharmacy _______

1 _______ 4 _______ 7 _______
2 _______ 5 _______ 8 _______
3 _______ 6 _______ 9 _______

Allergic To (Circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, Other _______