Name:	DOB:								
General Medical Information									
Describe the current medical problem/rea Present medications: Allergies to medications: Allergies (rash, itchiness or hives) to spe									
Other physicians currently treating you: Previous or other medical problems: Had any previous surgeries or hospitalization.	ations (include r	number of miscarriage	es and I	ive births	i):				
Females only. Are you pregnant, planning Do you smoke? No Yes Interested in stopping?	Cigarettes □	Pipe □ Cigars N				How M	luch		
Do you regularly drink alcohol? Do you regularly drink coffee? Are you under a lot of pressure at work?	s □No H s □No H	ow many ounces/beer ow many cups per day	y?						
Personal Medical History									
Have you ever had any of the following	(check all that a	pply):						gy n (mark ni ku (mirk V) m manna in W (ki) (t)	
\Box Chest pain/pressure/tightening \Box Asthma		☐ Kidney disease							
☐ Hypertension ☐ Dizzy S		ells □ Shortness of breath							
☐ Heart attack ☐ ☐ Cancer		☐ TB/Lung disorder							
□ Stroke □ □ Diabet		***************************************							
☐ Headaches ☐ Arthrit		☐ Skin disorders							
□ Glaucoma □ □ Diffic									
□ Allergies or Eczema □ □ C		☐ Cataracts ☐ Depression ☐							
☐ Memory loss ☐ Di		Digestive problems			☐ Blood in stool				
		t urinary infections □ Other							
Immunizations		Family History	,						
(Year last received, if known) Smallpox			Father		Father's Parents			Children	
Tetanus		High blood pressure							
Typhoid		Epilepsy							
Polio		Cancer							
		Eczema/Psoriasis							
Influenza		Heart attack/Stroke							
Pneumonia		Diabetes							
Rubella		Asthma					_	_	
Hepatitis		Hay fever							