

Print Name: _____ DOB: _____ Date: _____

Last

First

MEDICAL HISTORY:

<u>Condition:</u>	<u>Yes</u>	<u>No</u>	<u>YOUR HISTORY</u>	<u>FAMILY HISTORY</u>
Psoriasis, Eczema, Lichen Planus	<input type="radio"/>	<input type="radio"/>	_____	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	_____	_____
Heart Problems	<input type="radio"/>	<input type="radio"/>	_____	_____
Lung Problems	<input type="radio"/>	<input type="radio"/>	_____	_____
Stomach/Liver problems	<input type="radio"/>	<input type="radio"/>	_____	_____
Asthma/Hay Fever	<input type="radio"/>	<input type="radio"/>	_____	_____
Kidney Problems	<input type="radio"/>	<input type="radio"/>	_____	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	_____	_____
Cancer (skin or other)	<input type="radio"/>	<input type="radio"/>	_____	_____
Inflamed Veins/Phlebitis	<input type="radio"/>	<input type="radio"/>	_____	_____
Other	<input type="radio"/>	<input type="radio"/>	_____	_____

- Your occupation: _____
- Do you smoke? **Yes** **No** How many packs per day? _____ How many years? _____
- How much alcohol do you drink? _____
- Females:** Are you pregnant, nursing, or planning to become pregnant soon? **Yes** **No** #5081-1008

-over-

Are you allergic to any medications or skin creams? **Yes** **No** If yes, list below:

1. _____ 3. _____ 5. _____
 2. _____ 4. _____ 6. _____

- Have you had any joint totally replaced within the past 2 years? **YES** **NO**
- Do you have an artificial heart valve? **YES** **NO**
- Have you had Endocarditis? **YES** **NO**
- Have you had any repaired congenital heart disease? **YES** **NO**

Do you have **current** problems with any of the following?

<u>General Health:</u>	<u>Yes</u>	<u>No</u>	<u>If "Yes", please explain</u>	<u>List current medications:</u>
Fever, Weight Loss	<input type="radio"/>	<input type="radio"/>	_____	_____
Eyes	<input type="radio"/>	<input type="radio"/>	_____	_____
Ears/Nose/Throat/Mouth	<input type="radio"/>	<input type="radio"/>	_____	_____
Thyroid/Diabetes	<input type="radio"/>	<input type="radio"/>	_____	_____
Stomach/Bowel	<input type="radio"/>	<input type="radio"/>	_____	_____
Kidneys	<input type="radio"/>	<input type="radio"/>	_____	_____
Arthritis/Muscles/Joints	<input type="radio"/>	<input type="radio"/>	_____	_____
Headaches/Seizures	<input type="radio"/>	<input type="radio"/>	_____	_____
Recent Surgery (past year)	<input type="radio"/>	<input type="radio"/>	_____	_____
Insomnia & Psychological Stress	<input type="radio"/>	<input type="radio"/>	_____	_____
Asthma/Bronchitis	<input type="radio"/>	<input type="radio"/>	_____	_____
Chronic Cough	<input type="radio"/>	<input type="radio"/>	_____	_____
Irregular Heartbeat, Hypertension	<input type="radio"/>	<input type="radio"/>	_____	_____
HIV, Hepatitis	<input type="radio"/>	<input type="radio"/>	_____	_____
Other	<input type="radio"/>	<input type="radio"/>	_____	_____

Physician: Initial after reviewing/amending _____ MD; **or** complete history unobtainable due to: _____ #5081-1008