



Medical History

Date: _____

Name: _____ Age: _____ HT: _____ WT: _____

Primary MD: _____ Referring MD: _____

Reason for Office Visit: _____

Please Circle If You Have A History Of:

Asthma	Emphysema	Colon Disease	High Blood Pressure
Tuberculosis	Diabetes	Epilepsy	Cancer
Depression	Stroke	Kidney Disease	Anesthesia Difficulty
Dental Appliances	Heart Attack	Irregular Heart Beat	Heart Valve Disease
Chest Pain	Heart Failure	Pacemaker	Heart Surgery
Difficulty Climbing Stairs	Glasses/Contact Lenses	Difficulty Lying Flat	Abnormal Bleeding/Bruising
Other Medical Problem			

Describe: _____

Do You Smoke? Yes No Packs per day _____

Office Comment

Drug Allergies and Your Reaction: _____

Other Allergies: Food _____ Latex _____ Other _____

Medications and Reason For Taking: (No Dosage Necessary)

Prior Surgeries: _____

Females, Please Complete:

Last Menstrual Period: _____ Pregnant? Yes No

Date of Last Mammogram: _____ # Children _____