PATIENT'S MEDICAL HISTORY

PLEASE PLACE AN "X" NEXT TO ALL THAT APPLY:			
High Blood Pressure		Bronchitis	
Diabetes		Asthma	
Cancer		Pneumonia	
Heart Disease		Persistent Cough	
Chest Pain/Tightness		Seasonal Allergies	
Shortness of Breath		Abdominal Discomfort	
Swollen Ankles		Indigestion	
Palpitations		Change in bowel habits	
Lightheadedness		Thyroid Disease	
Arthritis		Lower back pain	
Frequent/Difficult Urination		Ulcers	
Nausea/Vomiting		Unexplained weight loss/gain	
Other:			

Recent Hospitalization or Surgery:______________________________ If yes, When? ________________

FAMILY HISTORY

Has any member of your family (parents, grandparents, siblings) ever had the following?

Illness	**Which Family Member?**
Cancer (Describe Type)	____
Hypertension (High Blood Pressure)	____
Heart Disease	____
Diabetes	____
Strokes	____
Mental Disease (anxiety, depression, etc.)	____
Glaucoma	____

Other:____

MEDICATIONS

NAME	DOSAGE	FREQUENCY		NAME	DOSAGE	FREQUENCY

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR ANY OTHER SUBSTANCES

*Please list the name of what you are allergic to and the type of reaction you had.*____________________________