MEDICAL HISTORY

This information is to enable us to help maintain the highest standards of safe and effective treatment. If the patient is a minor, the parent or legal guardian must complete this questionnaire and sign the authorization.

DATE:_____ **REFERRING DOCTOR:**_____

NAME:_____ **DATE OF BIRTH:**_____ **SEX: M F**

PAST MEDICAL HISTORY: (If applicable put an X in box)		
AIDS	Glaucoma	Pulmonary disease (lung)
Anemia	Heart attack	Renal dialysis
Alzheimers	Heart disease	Renal disease (kidney)
Arthritis	Hepatic Disease (liver)	Rheumatic fever
Asthma	Hiatal Hernia	Seizures
Bleeding disorder	High blood pressure	Stroke
Blood transfusion	Hypoglycemia	TB
Cataracts	Kidney stones	Thyroid problem
Cancer	Menopause	Ulcer
Chem/Alcohol dependency	Migraine headaches	Varicose Veins
Circulatory diseases	Mitral valve prolapse	OTHERS:
Diabetes	M.S.	
Emphysema	Phlebitis	
Epilepsy	Pregnant	
Exposure to hepatitis	Prostate problems	

PAST SURGERIES: (If applicable put an X in box)		
Amputation	Gallbladder surgery	Pacemaker
Appendix removed	Heart bypass	Thyroid surgery
Back surgery	Hemorrhoid surgery	Tonsils removed
Breast surgery	Hernia repair	Tubes tied
Cataract surgery	Hysterectomy	Vascular access device
Carotid artery surgery	Joint replacement	Vasectomy
Carpal tunnel surgery	Kidney surgery	Vein stripping
Cesarean section	Kidney stone removal	OTHERS:
Colon surgery	Lung surgery	
Colostomy	Mastectomy	
Ear surgery	Orthopedic surgery	

CHIEF COMPLAINT & DATE OF ONSET: _____

_____

LIST DATE & ANY STUDY/TEST PERFORMED FOR THIS COMPLAINT: _____

_____

COMPLETE OTHER SIDE OF THIS FORM