MEDICAL INFORMATION

Physician _____ City _____ Last Visit _____

Are you now, or have you been under a physician's care during the past 2 years? Yes No

Date of last complete physician examination _____

Insulin Dependent YES NO Diet Controlled YES NO

No. years diabetic _____ Avg Blood Sugar Range _____

Review of Systems (check each item that applies to you)

CONSTITUTIONAL (GENERAL)

____ Weight loss/over 10 lbs ____ Weight gain/over 15 lbs ____ Fever ____ Chills

____ Fatigue ____ Nausea ____ Other _____

EYES, EARS, NOSE & THROAT

___ Impaired sight ____ Eye disease ____ Eye pain ____ Vision problem

___ Eye infections-frequent ____ Glaucoma ____ Hearing loss ____ Ringing in ears

___ Ear infections ____ Dizzy spells ____ Fainting spells ____ Nose bleeds-frequent

___ Breathing difficulty ____ Sinus problems ____ Sore throat ____ Hoarseness

___ Speech difficulties ____ Dental problems ____ Abscessed (infected) teeth

___ Other _____

RESPIRATORY

____ Pneumonia/Pleurisy ____ Bronchitis/Chronic cough ____ Asthma/Wheezing ____ Shortness of breath

____ Tuberculosis ____ Emphysema ____ Hay fever/Allergies ____ Limited exercise tolerance

____ Use oxygen at home ____ C.O.P.D. ____ History of smoking ____ Other _____

CARDIOVASCULAR

____ Chest pain ____ Heart attack ____ High blood pressure ____ Open-heart surgery

____ Heart murmur ____ Chronic swelling ankles/feet ____ Palpitations ____ Irregular beat/pulse

____ Pacemaker ____ Mitral valve prolapse ____ Angioplasty ____ Artificial heart valve

____ Rheumatic fever ____ Circulation disorder ____ High cholesterol ____ Leg pain/walking

____ Leg pain/at rest ____ Tiredness in legs ____ Varicose vein ____ Phlebitis

____ Blocked arteries ____ Cold, numb feet ____ Angina - increased occurrence

____ Angina-increased intensity ____ Angina-new onset at rest ____ Change in chest pain pattern

____ Cardiac occlusive disease ____ Congestive heart failure ____ Other _____

GASTROINTESTINAL

____ Loss of appetite
____ Excessive hunger
____ Excessive thirst
____ Difficulty swallowing
____ Heart burn
____ Peptic ulcer
____ Persistent nausea
____ Vomiting
____ Abdominal pain/chronic
____ Gallbladder problem
____ Liver problem
____ Jaundice
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Cirrhosis
____ Diarrhea
____ Diverticulosis
____ Crohn's/colitis
____ Bloody or black stools
____ Heartburn/Refulx esophagitis
____ Other _____

BLADDER, KIDNEY

____ Frequent urination
____ Bladder infections-frequent
____ Blood in urine
____ Kidney stone
____ Renal failure
____ Swelling feet

FEMALE

____ Sexual transmissive disease
____ Breast cancer
____ Ovarian cancer
____ Postmenopausal
____ Oral contraceptives

MALE

____ Sexual transmissive disease
____ Prostate cancer

HEMATOLOGIC (BLOOD DISORDERS)

____ Anemia
____ Bruise easily
____ Cancer
____ Blood transfusion
____ Sickle cell disease/trait
____ Take Coumadin

ENDOCRINE

____ Diabetes
____ Thyroid disease
____ Other _____

NEUROLOGICAL (NERVOUS)

____ Seizures
____ Tremor/hands shake
____ Headaches-frequent
____ Stroke
____ Change in memory
____ Trouble with balance
____ Spine disease
____ Sciatica
____ Numbness
____ Muscle weakness
____ Polio
____ Change in sensation

BONE AND JOINT

____ Arthritis/Rheumatism ____ Back pain-recurrent ____ Gout ____ Osteoporosis

____ Osteoarthritis ____ Rheumatoid arthritis ____ Artificial joints _____

____ Severe arthritis of TMJ (jaw) or neck

SKIN

____ Rashes ____ Hives ____ Psoriasis ____ Eczema

____ Skin cancer ____ New growths ____ Color change-mole/wart

____ Thick scar or keloid formation ____ Other _____

PSYCHIATRIC

____ Sleeping difficulty ____ Concentration difficulty ____ Depression ____ Nervousness

____ Agitation ____ Memory loss ____ Moodiness ____ Suicidal thoughts

____ Phobias ____ Mental illness ____ Feelings of worthlessness

CHILDHOOD ILLNESS

____ Rheumatic fever ____ Scarlet fever ____ Chickenpox ____ Mumps

____ Measles ____ Herpes

ALLERGY/IMMUNOLOGY

____ Hay fever ____ Grass, mold, dust ____ Food allergies ____ HIV

____ Weak immune system ____ Chronic fatigue syndromes ____ Frequent infections

HIV positive? ____ Yes ____ No Any infection/past 6 months? ____ Yes ____ No

Hepatitis ____ Yes ____ No Other (please specify) _____

Wound healing history _____

Do you have a heart valve implant? ____ Yes ____ No

PLEASE CIRCLE ANY KNOWN ALLERGIES

Penicillin	Novocain	Codeine	Local anesthesia	Tape
Murcurials	Sulfa drugs	Aspirin	Other antibiotics	None

Other known allergies _____

PLEASE LIST ANY MEDICATIONS NOW BEING TAKEN (WITH DOSAGE)

Name of Medicine	Reason For Taking It	How Often Do You Take It?
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken Prednisone over the past 6 months? ___ Yes ___ No

PREVIOUS SURGERIES (WITH APPROXIMATE DATES)

_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

Mother ____ Living ____ Deceased Cause of death _____

Father ____ Living ____ Deceased Cause of death _____

Brother ____ Living ____ Deceased Cause of death _____

Sister ____ Living ____ Deceased Cause of death _____

Has anyone in your family ever been treated for:

	You	Father	Mother	Brother	Sister	Children	Grandparents	Aunt/Uncle
Arthritis	____	____	____	____	____	____	____	____
Cancer	____	____	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____	____	____
Foot problems	____	____	____	____	____	____	____	____
Gout	____	____	____	____	____	____	____	____
Neuromuscular disease	____	____	____	____	____	____	____	____
Peripheral vascular disease	____	____	____	____	____	____	____	____
Tuberculosis	____	____	____	____	____	____	____	____
Varicose veins	____	____	____	____	____	____	____	____
Heart disease	____	____	____	____	____	____	____	____
Bleeding disorder	____	____	____	____	____	____	____	____
Stroke	____	____	____	____	____	____	____	____

Do you smoke? ___ Yes ___ No No. packs per day _____

Previously smoked? ___ Yes ___ No No. of years _____

Do you drink alcohol or beer? ___ Yes ___ No

If yes, how much ___ 1-2/week ___ 1-2/day ___ more than 2 daily