PATIENT'S NAME:________________________________

MEDICAL HISTORY

Check/list any condition(s) in your history or that you currently have:

☐ Anemia	☐ Fainting Spells	☐ Leg Cramps	☐ Sickle Cell Anemia
☐ Asthma	☐ Gout	☐ Liver Problems	☐ Stomach Ulcer
☐ Arthritis	☐ Heart Trouble	☐ Low Back Problems	☐ Stroke
☐ Blood Problems	☐ Hepatitis	☐ Phlebitis	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Poor Circulation	☐ Unequal Leg Length
☐ Diabetes	☐ HIV (AIDS)	☐ Prone to Infection	☐ Varicose Veins
☐ Epilepsy (seizure)	☐ Kidney Problems	☐ Shortness of Breath	

☐ Other________________________________

Additional system review (check/list any other condition(s) you currently have

☐ Fever	☐ Chest pain	☐ Nervous disorder	☐ Stomach problems
☐ Nose/sinus problems	☐ Muscle pain	☐ Anxiety	☐ Weight gain/loss
☐ Sore throat	☐ Nerve pain	☐ Mental/Emotional problems	☐ Skin problems
☐ Swallowing difficulty	☐ Neurological/muscular problems	☐ Lymph gland problems	☐ Ulcers/skin changes
☐ Ear/hearing difficulty	☐ Migraine headaches	☐ Thyroid problems	☐ Sores in mouth
☐ Allergies (seasonal)	☐ Poor vision	☐ Hormone problems	☐ Breast lumps
☐ Dizziness/balance difficulty	☐ Eye Problems	☐ "Gland" problems	☐ Blood in urine
☐ Fast/slow pulse	☐ Glaucoma		☐ Urine/Kidney problems
☐ "Bleeder"			

Other________________________________

Check *yes or no* to the following:

Do you smoke? ☐ Yes ☐ No If yes, amount________________

Do you drink alcohol? ☐ Yes ☐ No If yes, amount________________

Do you take illegal drugs? ☐ Yes ☐ No If yes, amount________________

Do you take any medication? ☐ Yes ☐ No (include prescriptions, over the counter meds & vitamins

If yes, list name and dosage:________________ ________________

________________ ________________

________________ ________________

________________ ________________

Check any allergies you have:

☐ Adhesive Tape	☐ Aspirin	☐ Novacaine	Other________
☐ Antibiotics	☐ Codeine	☐ Penicillin	Other________
☐ Anticoagulants	☐ Iodine	☐ Seafoods	Other________

Please list any significant surgeries you have had within the last 10 years

________________________________ Date:________

________________________________ Date:________

________________________________ Date:________

Please list any significant hospitalizations you have had within the last 10 years

________________________________ Date:________

________________________________ Date:________

________________________________ Date:________

If female, could you be pregnant? ☐ Yes ☐ No

Name of family physician:________________ Date of Last Exam:________

PATIENT'S SIGNATURE________________________ DATE____________