PATIENT HISTORY

PATIENT'S NAME ______________________________

1. STATE IN YOUR OWN WORDS YOUR MEDICAL REASON(S) FOR COMING TO OUR OFFICE.

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2. PLEASE LIST ALL MEDICATIONS YOU USE ______________________________

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3. FOR WOMEN ONLY - ARE YOU PREGNANT ? __________ IF SO, HOW MANY MONTHS ? __________

4. INDICATE WHICH OF YOUR RELATIVES HAVE HAD ANY OF THE FOLLOWING DISEASES :

CANCER ______________________

HEART TROUBLE ______________

KIDNEY STONES ______________

STROKES ____________________

DIABETES ______________________

HIGH BLOOD PRESSURE ______________

MENTAL / EMOTIONAL DISEASE ______________

ARTHRITIS ______________________

5. PLEASE INDICATE BY CHECKING "YES" OR "NO" IF YOU HAVE HAD ANY SIGNIFICANT PROBLEMS IN THE BELOW AREAS. PLEASE COMMENT ON SPECIAL PROBLEMS.

YES	NO	NATURE OF PROBLEM	COMMENT, GIVE DATE, OR CIRCLE
		RECENT WEIGHT LOSS	
		HEADACHES	
		TROUBLE WITH VISION OR HEARING	
		ALLERGIES OR HAYFEVER	
		THYROID	OVERACTIVE / UNDERACTIVE
		DIABETES - HOW LONG?	INSULIN / DIET / PILLS
		SKIN / SCARRING TENDENCY	
		ANEMIA OR ABNORMAL BLEEDING	
		HEART OR CIRCULATION	HEART MURMUR, MITRAL VALVE PROLAPSE
		HIGH BLOOD PRESSURE	
		CHEST PAINS	
		LUNGS	PNEUMONIA / TB / ASTHMA / OTHER
		SHORTNESS OF BREATH	COUGH / PLEURISY / WHEEZING / OTHER
		LIVER OR GALL BLADDER DISEASE	
		STOMACH TROUBLE	
		SWELLING IN FEET OR ANKLES	
		ARTHRITIS OR GOUT	JOINT PAIN OR JOINT STIFFNESS