

**MEDICAL INFORMATION**

**Page 1**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Blood Type:** \_\_\_\_\_

**Reason for consultation:** \_\_\_\_\_

\_\_\_\_\_

**Have you consulted with another doctor? YES NO**

**Who is your family doctor (the doctor you see for most of your problems?)**

\_\_\_\_\_ **Phone number** \_\_\_\_\_

**When was your most recent physical check up? \_\_\_\_\_ EKG? \_\_\_\_\_ Chest Xray? \_\_\_\_\_**

**Please list all medications, prescriptions and non-prescriptions, you are currently taking or take on a routine basis (include dosage):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you left or right-handed? LEFT RIGHT**

**Medication Allergies: CODEINE SULFA MORPHINE PENICILLIN MYCINS**

**TETRACYCLIN OTHER (Please specify) \_\_\_\_\_**

**Are you allergic to any topical preparations? TAPE BETADINE**

**OTHERS (please specify): \_\_\_\_\_**

**The name of the pharmacy you use? \_\_\_\_\_ Phone Number \_\_\_\_\_**

## MEDICAL INFORMATION

Page 2

**Family History—Please indicate if anyone in your immediate family has had any of the following conditions:**

	<b>Father</b>	<b>Mother</b>	<b>Brother(s)</b>	<b>Sister(s)</b>	<b>Children</b>
<b>Age</b>					
<b>Deceased</b>					
<b>No Health Conditions</b>					
<b>Arthritis</b>					
<b>Asthma/Allergies</b>					
<b>Bleeding Tendancy</b>					
<b>Coloretal Cancer</b>					
<b>Alcoholism</b>					
<b>Cancer</b>					
<b>Coronary Disease</b>					
<b>Heart Attack</b>					
<b>Reaction to Anesthesia</b>					
<b>Tuberculosis</b>					
<b>Blood Clots</b>					
<b>Pulmonary Embolism</b>					
<b>Stroke</b>					
<b>Genetic Disorder</b>					
<b>COPD</b>					
<b>Mental Illness</b>					
<b>Diabetes Type 2</b>					
<b>Diabetes Type 1</b>					
<b>Hypertension</b>					
<b>Hyperlipidemia</b>					
<b>Thyroid Disease</b>					

**MEDICAL INFORMATION**

Have you ever had any of the following conditions? Check all that apply:

<b>CONDITION: Details</b>	<b>YES</b>	<b>NO</b>
Heart Disease		
Cancer		
Stroke		
Anxiety		
Asthma		
COPD		
Backache		
Depressive Disorder		
Diabetes Type 2		
Diabetes Type 1		
Esophageal Reflux		
Hypercholesterolemia		
Hyperlipidemia		
Hypertension		
Thyroid Disease		
Obesity		
Weight Change over the past year? CIRCLE ONE: None, Gained 0-5 lbs, Lost 0-5 lbs., Gained 5-10 lbs., Lost 5-10 lbs., Gained 10-20 lbs., Lost 10-20 lbs., Gained 20+ lbs., Lost 20+ lbs.		
Males: Do you have difficulty urinating?		
Females: Do you have fibrocystic or other breast changes?		
Last mammogram: If done list month/year _____		
Pregnant Now?		
Number of pregnancies		
Surgical History:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Date of Surgery:                      Procedure:		
Marital Status: Married, Single, Divorced, Widowed		
Children: Son # ___ Ages:                      Daughters# ___ Ages:		
Work: FT PT Unemployed		
<b>CONTINUED ON NEXT PAGE</b>		

<b>MEDICAL INFORMATION CONTINUED: PAGE 4</b>		
<b>Exercise: Circle ONE:</b> None, sedentary, Occasional Light Activity Occasional Aerobic Occasional Weight Lifting/Resistance 4 times or more per week Light Activity 4 times + per week Aerobic 3 times or more Weight Lifting/Resistance		
<b>Do you smoke? (even a little) How much/how many years?</b>		
<b>Desire to Quit Smoking?</b>		
<b>Do you now or have you ever used alcohol/CIRCLE ONE:</b> Never, Rare, Daily, Weekly, A few times a Week, Monthly		
<b>Do you now or have you ever used illicit drugs/CIRCLE ONE:</b> Never, Rare, Daily, Weekly, A few times a Week, Monthly		
<b>Do you use Caffeine/CIRCLE ONE;</b> Never, Rare, Daily, Weekly, A few times a Week, Monthly		
<b>Do you use products containing aspirin or ibuprofen on a regular basis (How often?)</b>		