PLEASE COMPLETE ALL INFORMATION

Reason for visit _____

MEDICAL HISTORY

Have you/Do you have problems with the following? (Please check only those that apply)

____ Anxiety	____ Hepatitis A/B/C	____ Seizures
____ GERD	____ AIDS/HIV	____ Sleep Apnea
____ Depression	____ Asthma	____ Parkinson's
____ Cirrhosis	____ Dementia	____ AFIB
____ Heart Attack/Murmur/ Disease	____ Rheumatic Fever	____ Gout
____ Abnormal Kidney Function	____ Liver Disease	____ Diabetes I / II
____ High Blood Pressure	____ Glaucoma	HbA1C _____
____ High Cholesterol	____ Arthritis	____ Peripheral Vascular Disease
____ COPD	____ Multiple Sclerosis	____ Neuropathy
____ Stroke	____ Osteoporosis	____ Thyroid
____ Blood Clot-Location _____	____ Back Pain	____ on Oxygen
____ Abnormal Scar Formation	____ Cancer-Specify _____	

Are you Currently Pregnant? Yes____ No ____ Any Complications? _____

Height _____ Weight _____ Shoe Size _____

Width: Narrow □ Regular □ Wide □

Other Medical Conditions/Anything else our physicians should know about your medical history:

_____

Immediate Family History of: (List Who)

Cancer _____ **High Blood Pressure** _____

Heart Condition _____ **Diabetes** _____

List **ALL** medications you are **currently** taking:

_____

_____

List **ALL** allergies to medications / food:

_____

List **ALL** previous surgeries and any reactions to anesthetics:

_____

Did you ever use tobacco products? _____

Do you smoke or chew tobacco per day? _____ How many cigarettes per day? _____

How many alcohol drinks do you have per week? _____

Do you use any illegal/illicit drugs beside prescription medication? _____ Do you/How often use marijuana? _____

Please circle any of the following conditions **you are CURRENTLY experiencing**: Fever, chills, nausea, vomiting, weight loss, weight gain, lumps, sores, rashes, dizziness, eye sight changes, headaches, problem swallowing, ringing ears, problem breathing, pneumonia, asthma, chest pain, chest tightness, heart palpitations, heart murmur, abdominal cramping, bloody stools, diarrhea, stomach burning, discharge, pain with urination, limb deformity, loss of consciousness, loss of use of any limb, blackouts, seizures, night sweats, excessive thirst, frequent night urination, excessive hunger, excessive bleeding, excessive bruising, menopause symptoms. Other, please list;

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