MEDICAL HISTORY

THE FOLLOWING INFORMATION WILL HELP YOUR PHYSICIAN PLAN YOUR CARE.
PLEASE PRINT AND COMPLETE THIS SECTION

Name: ________________________________ Age ________ Height ________ Weight _________

What problem are you seeking care for?

____

____

____

Check and or list all illnesses/problems you have been treated for in the past and present:

___ None	___ heart attack	___ angina	___ diverticulitis
___ heart murmur	___ mitral valve prolapse	___ high blood pressure	___ Crohn's disease
___ stroke	___ asthma	___ low blood pressure	___ ulcerative colitis
___ blood clots	___ stomach trouble/ulcer	___ bleeding disorder	___ hepatitis
___ COPD	___ emphysema	___ kidney problems	___ seizures
___ bladder	___ arthritis	___ diabetes	___ tuberculosis
___ cancer	___ depression	___ cirrhosis	___ other

____

____

____

Please list any surgeries you have had:

____

____

____

____

____

LIST ALL MEDICATION YOU CURRENTLY TAKE, THE DOSE AND HOW OFTEN

______ NONE DRUG ALLERGIES ____

MEDICATION, DOSE AND FREQUENCY

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____