

MEDICAL DATA BASE

All information is Confidential

Reason for Visit _____

Name _____ Age _____ Date _____
(First) (Middle) (Last)

Occupation _____ Hobbies _____

Check (✓) if you have had a **HISTORY** of:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches or nervous disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney or bladder problems |
| <input type="checkbox"/> Heart condition or high blood pressure | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Anemia or blood disorders |
| <input type="checkbox"/> Lung disorder, bronchitis, pneumonia | <input type="checkbox"/> Hives | <input type="checkbox"/> Venereal disease, herpes, gonorrhea |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> AIDS or HIV infection |
| <input type="checkbox"/> Jaundice, hepatitis, liver disease | <input type="checkbox"/> Allergies, Sinus Problems | <input type="checkbox"/> Bone fractures |
| <input type="checkbox"/> Stomach, bowel or gallbladder problems | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Birth defects or inherited disease |
| <input type="checkbox"/> Blood clots in legs or lungs | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Abnormal menstrual periods |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Other Skin Problems - Describe: _____ | |

In your **FAMILY** is there a HISTORY of:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hives | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Eczema | <input type="checkbox"/> Other Cancer _____ |
| <input type="checkbox"/> Inherited disease or birth defects | <input type="checkbox"/> Allergies, Sinus Problems | <input type="checkbox"/> Anemia or blood disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Other Skin Problems - Describe: _____ | |

HOSPITALIZATIONS List all surgeries and/or serious illnesses.

Mo/Yr	Illness or operation	Complications
/		
/		
/		
/		
/		
/		
/		

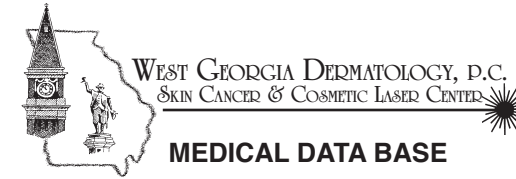
WOMEN Are you pregnant? (yes/no) _____ How do you keep from getting pregnant? _____
 Are you nursing? (yes/no) _____ Are you taking birth control pills? (yes/no) _____

Are you **ALLERGIC** to any drugs? (Please list) _____

Present **MEDICATIONS** _____

OTHER SUBSTANCE use (amount and frequency) Alcohol _____ Tobacco _____ Other _____

Have you ever had a blood **TRANSFUSION**? (yes/no) Problems with Anesthetics? (yes/no) Describe _____



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