



(Please Print Clearly)

GENERAL HEALTH INFORMATION

NAME _____ Referring Physician _____

Date of Birth _____ Age _____

Reason for Visit _____

Height _____ Weight _____

Past Medical History

Medical: Do you now have, or have you ever had any of the following disorders?

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia or other Blood Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Nerve Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Decreased Vision |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Excessive Tearing |
| <input type="checkbox"/> Other Lung Disease | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Wound Healing Problems |
| | | <input type="checkbox"/> Keloids or Excessive Scar Formation |

Any conditions or illnesses not listed above?

Surgical: Please list all operations you have had, including cosmetic surgery. Include hospitals and dates if known.

Medications: Please list all medications you are currently taking.

(include Aspirin, Birth Control Pills, Vitamins, Etc.)

Allergies: Drug Allergies (list)

Other (tape, iodine, soaps, etc.)

Other: Do you smoke? _____ Approx. packs/day _____ Do you drink? _____ Approx. amount/week _____

List any diseases that run in your family
