

Patient History

Please Circle any medical conditions that you have or have had.

Aids/HIV	Arthritis	Asthma
Blood Disorders	Chemical Dependency	Diabetes
Kidney Disorders	Heart Disease	Hepatitis/Jaundice
High Blood Pressure	High Cholesterol	Liver Problems
Low Blood Pressure	Lung Problems	Psychiatric Disorders
Thyroid Problems	Tuberculosis	Ulcers
		Cancer
		Gout
		Neuropathy
		Stroke
		Epilepsy/Seizures

Please circle any allergies that you are aware of Adhesive tape Aspirin Codeine Demerol Iodine
Local Anesthetic Penicillin Seafood Sulfa Other _____

Please list any medications that you are taking _____

Please list any surgeries that you have had. _____

Do you or have you had any of the following?

Eyes: cataracts, blurred vision, impaired vision, blindness, wear glasses or contacts, other _____

Ears, Nose, Mouth, Throat: tinnitus (ringing in ears), halitosis (chronic bad breath), diminished hearing, deafness, difficulty swallowing, other _____

Cardiovascular: congestive heart failure, MI(heart attack), palpitations, high blood pressure, CVA(stroke), angina/chest pain, blood clots, varicose veins, lymph edema, other heart problems _____

Respiratory: asthma, shortness of breath, sleep apnea, snoring, sinus congestion/infections, other breathing problems _____

Gastrointestinal: nausea, vomiting, diarrhea, blood in stool, ulcers, reflux, other _____

Genitourinary: painful urination, blood in urine, frequent urination, impotence, STDs, other _____

Musculoskeletal: back pain, joint pain, muscle pain, bone pain, scoliosis, other _____

Integumentary: dermatitis, eczema, tinea (athlete's foot), psoriasis, rash, or other _____

Neurological: anesthesia, paraesthesia (decreased or unusual sensations), neuropathy, seizures, tremors, other _____

Psychiatric: anxiety, depression, bingeing, paranoia, other psychiatric concerns _____

Endocrine: diabetes mellitus, fatigue, or unexplained weight loss or gain, other _____

Immunologic: allergies, gout, rheumatic disease, other _____

Do you smoke or use tobacco products? YES NO Cigarettes Pipe Cigar Chewing Tobacco
Do you drink alcohol? YES NO How much and how often? _____

List any medical conditions that run in your immediate family (specify which family member). _____

