

# Personal/Family Medical History:

Patient Name \_\_\_\_\_

Acct.# \_\_\_\_\_ DOB \_\_\_\_\_

|                               | Please mark if <b>you</b> have any of the following: | Please mark if a <b>family member</b> has any of the following: |
|-------------------------------|--|---|
| <b>General:</b>               |  |   |
| Problems with anesthesia      | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Cancer                        | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Environmental Allergies       | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Endocrine:</b>             |  |   |
| Diabetes                      | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Thyroid Disease               | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Hematology:</b>            |  |   |
| Anemia                        | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Bleeding Disorders            | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Infectious Diseases:</b>   |  |   |
| T.B.                          | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Hepatitis                     | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Lyme Disease                  | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Other:                        | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Cardiovascular:</b>        |  |   |
| High Blood Pressure           | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Chest Pain/Angina             | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Congestive Heart Failure      | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Heart Attack                  | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Heart Murmur                  | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Irregular Heart Beat          | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| DVT                           | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Phlebitis                     | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Swelling of Feet              | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Pulmonary:</b>             |  |   |
| Asthma                        | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Emphysema/COPD                | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Pneumonia                     | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Chronic Cough                 | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Pulmonary Embolism            | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Gastrointestinal:</b>      |  |   |
| Ulcers                        | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Gastric Reflux (GERD)         | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Irritable Bowel Syndrome      | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Renal:</b>                 |  |   |
| Kidney disease                | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Kidney Stones                 | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Musculoskeletal:</b>       |  |   |
| Arthritis                     | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Back Disorders                | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Backache                      | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Osteoporosis                  | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| <b>Neurological:</b>          |  |   |
| Headaches                     | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Dizziness                     | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Blurred Vision/Double Vision  | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Epilepsy/Convulsions/Seizures | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Stroke                        | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Nervous Disorder              | <input type="checkbox"/>                             | <input type="checkbox"/>  |
| Peripheral neuropathy         | <input type="checkbox"/>                             | <input type="checkbox"/>  |

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_