

MEDICAL HISTORY

Does anyone in your family have:	No	Yes	Comments: If yes, explain:	<i>My Family</i>
Obesity or excessive weight?				
Alcoholism or drug abuse? You?				
High blood pressure?				
Diabetes?				
Coronary heart disease?				
Arteriosclerosis or stroke?				
High cholesterol?				
Gallstones?				
Have you or are you now:	No	Yes	Comments: If yes, explain:	<i>Me</i>
Had any operations?				
Had any hospitalizations?				
Had any pregnancies?				
On medications?				
Have any allergies to medicines?				
Seasonal allergies?				
Headaches? What do you take for them?				
Vision problems? Glaucoma?				
Hearing problems?				
Sinus infections?				
Thyroid problems?				
Lung problems, e.g. pneumonia, asthma?				
Heart problems or high blood pressure?				
Gastrointestinal problems, ulcer, colitis?				
Hepatitis or jaundice?				
Gall bladder problems?				
Urinary bladder problems?				
Kidney problems?				
Arthritis?				
Muscle weakness or paralysis?				
Diabetes or metabolic disorder?				
Anemia or blood disorder?				
Depression or anxiety?				
Sleeping disorder?				
Excessive snoring?				
<i>For women only:</i>				
When was your last period?				
Have you had any female problems?				
When was your last pelvic & Pap exam?				
Have you had breast problems?				
Any breast biopsies?				
<i>For men only:</i>				
Have you had any prostate problems?				
<i>Is there anything else about your health the doctor should know?</i>				
Name:			Date:	