MEDICAL HISTORY

Have you been diagnosed with or had problems with any of the following? Please circle all that apply.

Arthritis or Gout	Blood Diseases/Clotting Problems	Bladder or Prostate Cancer Type:
Breast Lump/Cyst	Breathing/Lungs	Hearing
Diabetes Years	Eyes/Vision	Venereal Disease (VD)
Heart Disease	High Blood Pressure	Mental Illness
Liver/Jaundice/Hepatitis	Kidney Diseases	Stroke
Seizures	Stomach/Bowel	
Thyroid	Tuberculosis	
Blood Transfusions	Allergies Type	

MEDICATIONS

Please list all medications (prescription and nonprescription) that you are currently taking. Use back of page if necessary.

MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FEMALES ONLY:

PREGNANCIES: TOTAL # PREMATURE MISCARRIAGES ABORTIONS

ARE YOU ON HORMONE REPLACEMENT THERAPY? ( ) YES ( ) NO

ARE YOU ALLERGIC TO ANY MEDICATION(S)? Y_____N_____ IF YES, LIST BELOW:

_____

PAST SURGERY:

BREAST ( ) APPENDIX ( ) GALLBLADDER ( ) COLON ( ) HERNIA ( ) HEMORRHOIDS ( )

OTHER:_____

SOCIAL HISTORY:

TOBACCO: YES NO CURRENTLY:_____STOPPED:_____WHEN?_____

CIGARETTES: PACKS PER DAY_____ NUMBER OF YEARS_____

CIGARS: NUMBER PER DAY _____ NUMBER OF YEARS _____PIPE:_____

ALCOHOL: YES NO TYPE:_____AMOUNT_____

DRUG ABUSE HISTORY:

NONE ____ MARIJUANA_____COCAINE/CRACK_____HEROIN_____AMPHETAMINES/SPEED_____

	YES	NO
DO YOU HAVE CHRONIC TINGLING/BURNING IN YOUR HANDS OR FEET?	( )	( )
HAVE YOU EVER EXPERIENCED EPISODES OF EXTREME PAIN IN YOUR HANDS AND OR FEET OF UNKNOWN CAUSE, POSSIBLY ACCOMPANIED BY FEVER?	( )	( )
DO YOU HAVE TROUBLE SWEATING OR EXERCISING?	( )	( )
DO YOU FIND HEAT OR COLD HARD TO TOLERATE?	( )	( )
DO YOU FREQUENTLY HAVE GASTROINTESTINAL PROBLEMS SUCH AS PAIN AND BLOATING AFTER EATING, OR NAUSEA, CRAMPS OR DIARRHEA?	( )	( )
DO YOU HAVE SMALL RAISED REDDISH-PURPLE SPOTS ON YOUR SKIN, ESPECIALLY IN THE "BATHING TRUNK" AREA?	( )	( )
DO YOU HAVE A FAMILY HISTORY OF EARLY CARDIAC OR VALVULAR DISEASE RENAL FAILURE OR STROKE?	( )	( )

PATIENT'S NAME (PLEASE PRINT)_____DATE OF BIRTH_____