MEDICAL INFORMATION
Page 1

NAME: ____ **DATE:** _______________

Date of Birth: _____________ **Age:** ______ **Height:** _______ **Weight:** _______ **Blood Type:** ________

Marital Status: (circle) M S D W **Work: (circle) FT PT Unemployed Retired Student**

Reason(s) for consultation: ____

____

Have you consulted with another doctor? YES / NO
Who is your family doctor (the doctor you see for most of your problems)?

Name____ **Phone number:**_______________________

When was your most recent physical checkup? __________ **EKG?** __________ **Chest X-ray?**__________

Please list all medications, prescriptions and non-prescriptions, you are currently taking or take on a routine basis (include dosage):

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Medication Allergies: CODEINE SULFA MORPHINE PENICILLIN MYCINS TETRACYCLIN
OTHER (Please specify) ____

Are you allergic to any topical preparations? TAPE BETADINE
OTHERS (please specify):____

Name & Address & Phone Number of Pharmacy: ____

____

Exercise: Circle ONE:
- **None, sedentary, Occasional Light Activity**
- **Occasional Aerobic**
- **Occasional Weight Lifting/Resistance**
- **4 times or more per week Light Activity**
- **4 times + per week Aerobic**
- **3 times or more Weight Lifting/Resistance**

MEDICAL INFORMATION PAGE 2

Have you ever had any of the following conditions? Check all that apply:

CONDITION: Details	YES	NO
Bleeding Disorder		
Blood Clots		
Heart Disease		
Cancer		
Stroke		
Anxiety		
Asthma		
COPD		
Backache		
Diabetes Type 1		
Esophageal Reflux		
Hypercholesterolemia		
Hyperlipidemia		
Hypertension		
Thyroid Disease		
Obesity		
Weight Change over the past year? CIRCLE ONE: None, Gained 0-5 lbs, Lost 0-5 lbs., Gained 5-10 lbs., Lost 5-10 lbs., Gained 10-20 lbs., Lost 10-20 lbs., Gained 20+ lbs., Lost 20+ lbs.		
Males: Do you have difficulty urinating?		
Females: Do you have fibrocystic or other breast changes?		
Last mammogram: If done list month/year _____		
Pregnant Now? Number of pregnancies?		
Children: Son #____ Ages: Daughters#_____ Ages:		
Surgical History:		
Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
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Date of Surgery: Procedure:		
Date of Surgery: Procedure:		
Do you smoke? (even a little) How much/how many years?		
Desire to Quit Smoking?		
Do you now or have you ever used alcohol? CIRCLE ONE: Never, Rare, Daily, Weekly, A few times a Week, Monthly		
Do you now or have you ever used illicit drugs? CIRCLE ONE: Never, Rare, Daily, Weekly, A few times a Week, Monthly		
Do you use Caffeine? Never, Rare, Daily, Weekly, A few times a Week, Monthly		
Do you use products containing aspirin or ibuprofen on a regular basis (How often?)		

MEDICAL INFORMATION PAGE 3

Family History—Please indicate if anyone in your immediate family has had any of the following conditions:

	Father	Mother	Brother(s)	Sister(s)	Children
Age					
Autoimmune					
Deceased					
No Health Conditions					
Arthritis					
Asthma/Allergies					
Bleeding Tendency					
Colorectal Cancer					
Alcoholism					
Cancer					
Coronary Disease					
Heart Attack					
Reaction to Anesthesia					
Tuberculosis					
Blood Clots					
Pulmonary Embolism					
Stroke					
Genetic Disorder					
COPD					
Mental Illness					
Diabetes Type 2					
Diabetes Type 1					
Hypertension					
Hyperlipidemia					
Thyroid Disease					
Other					