CONFIDENTIAL MEDICAL HISTORY

Date: ____________________

Name: ____________________________________ **Age:** ______ **Marital Status:** S M D W **Religion:**_________________________

General Health: EXCELLENT / GOOD / FAIR / POOR **Ethnic Background:** ____

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING?
(PLEASE MARK EACH AND EVERY INQUIRY)

	YES	NO		YES	NO		YES	NO
Visual disturbances/eye problems			Extra heart beats/irregular or racing pulse			Tarry/bloody stools		
Do you wear contacts?			Abnormal EKG			Hemorrhoids		
Glaucoma/eye disorder			Digitalis treatment (for heart)			Problem constipation		
Airway obstruction (nose)			Dropsy/heart failure			Palsy/paralysis		
Fracture of neck/spine			Rheumatic fever			Alcoholism		
Thyroid/Goiter problems			Heart murmurs or Mitral Valve Prolapse			Esophageal varices		
Breast cysts, tumors, abscesses			Bleeding Ulcers			Kidney/renal disease		
Nipple discharge			Other heart disorder			Abnormal bleeding tendency		
Asthma, other than as a child			Stroke/Paralysis			Abnormal bleeding after tooth extraction		
Bronchitis, in last 10 years			Blood pressure increase			Blood disorder		
Pneumonia, in last 10 years			Cancer			Blood transfusion		
TB (Tuberculosis)			Diabetes			Skin disorders		
Emphysema			Nervous disorder			Arthritis		
Coughing blood			Nervous breakdown			Hay fever		
Vomiting blood			Hepatitis A,B, C, D			Major allergies		
Shortness of breath			Yellow jaundice			Self-destructive tendencies		
Heart trouble/heart attack			Gallbladder problems			Insomnia		
Fainting			Cirrhosis of the liver			Drug habit		
Anemia			Frequent indigestion or bleeding ulcers			Psychiatric treatment		
Irregular pulse/palpitation			Colitis			Psychiatric hospitalization		
Chest pain			AIDS, ARC or positive AIDS test					

Explanation of above "yes" answers: ____
____

1. Have you had a bad cold/influenza in the past month? *YES / NO* If so, when?____________________ Are symptoms still present? *YES / NO*

2. Are you allergic to any medications, food products, latex, skin adhesives or any other substances? *YES / NO*
Which?____What are your symptoms?_________________________________

3. Do you have any family history of cancer, heart trouble or stroke? *YES / NO* If so, who and which condition(s)? ______________________
____

4. Do you have cocktails regularly or consume beer, wine or other alcoholic beverages? *YES / NO* If so, what and how often? _____________
____

5. Do you smoke now or use any form of tobacco or nicotine (including Nicorette Gum or patches)? *YES / NO* If so, how much? Have you smoked in the past?____

6. Is there any possibility that you are pregnant? *YES / NO* When was your last menstrual period?____________ Was it normal? *YES/ NO*

7. Please list all present medications, including birth control pills, hormones vitamins, herbs, and natural dietary supplements:____________
____

(OVER)

(CONTINUED...)

8. Have you ever been on cortisone/steroid treatment? *YES / NO* When?____

9. Have you ever had cold sores, herpes, fever blisters or shingles? *YES / NO* If so, where and when?____________________________________

10. Please list all surgical procedures, with approximate date and reasons (please include cosmetic surgery procedures):__________________
____
____
____

11. Please list hospitalizations, including dates and reasons____
____

12. How many pregnancies? ________ Births?_________ Breastfed? _________How long?____

13. Previous mammogram? *YES / NO* When?___________________ Where?____

14. Have you ever been under psychiatric care? *YES / NO* When and by Whom? ____

15. When was your last physical exam?____________ By whom? ____

16. When was your last eye exam?_______________ By whom? ____

17. When was your last chest x-ray and where?____

18. How much and what kind of exercise do you do? ____

19. Are you a vegetarian? *YES / NO* If so, for how long? ____

20. Do you use amphetamines, diet control pills, herbal stimulants like "Ephedra" or use cocaine or other stimulants? *YES NO*
If so, which? ____

21. Do you use mind-altering or "recreational" drugs, sedatives, tranquilizers or such substances such as marijuana, "ice," ecstasy, prescription pain medications, sleeping pills, sedatives or tranquilizers? *YES / NO* If so, which and how much? ____
____

22. Have you used any erectile enhancement medications such as "Viagra," "Cialis" or "LaVetra"? *YES/NO* If so, when and which?
____

____

PATIENT SIGNATURE

COMMENTS BY DOCTOR: