Name: _____ **Age:** _____ **Marital Status:** M S W D

Date of Birth: _____

Problem or Present Illness: _____

Past Medical History: **(Check Items You Have or Have Had)**

o ADD	o HEART ATTACK (acute myocardial infarction)
o ADHD	o HEMORRHOIDS
o ANEMIA	o HEPATITIS
o ARTHRITIS	o HIGH BLOOD PRESSURE (hypertension)
o ASTHMA	o HIGH CHOLESTEROL
o CANCER	o IRREGULAR HEART BEAT (palpitations)
o COLITIS	o JAUNDICE
o COLON POLYPS	o KIDNEY STONES (urinary calculus)
o CORONARY ARTERY DISEASE	o MITRAL VALVE DISORDER
o DEPRESSION	o NERVOUS BREAKDOWN
o DIABETES MELLITUS, TYPE I	o PNEUMONIA
o DIABETES MELLITUS, TYPE II	o RHEUMATIC FEVER
o EMPHYSEMA	o SEIZURES
o EPILEPSY	o STOMACH ULCER
o ESSENTIAL HYPERTENSION	o THYROID DISORDER
o GALLSTONES (cholecystitis)	o TUBERCULOSIS
o GLAUCOMA	OTHER: _____
o GERD	
o HEARING LOSS	

Past Surgical History:

HOSPITAL: _____ DATE: _____
HOSPITAL: _____ DATE: _____
HOSPITAL: _____ DATE: _____
HOSPITAL: _____ DATE: _____
SURGERIES: _____ DATE: _____
SURGERIES: _____ DATE: _____
SURGERIES: _____ DATE: _____
SURGERIES: _____ DATE: _____

Medication List:

_____
_____
_____
_____
_____

Allergy List:

ENVIRONMENTAL: _____
FOOD: _____
MEDICATIONS: _____

Family Medical History: **(Please Specify on Grandparents if Paternal or Maternal)**

BROTHERS DECEASED AGE: _____ REASON: _____
BROTHERS LIVING _____
CHILDREN DECEASED AGE: _____ REASON: _____
CHILDREN LIVING _____
FATHER DECEASED AGE: _____ REASON: _____
FATHER LIVING _____