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To better assist you on your first visit, please fill up this form

Name: _____ Date: _____

Reason for your visit: _____

Medical History (Please Circle)

High Blood Pressure	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
Cancer	No	Yes
Arthritis	No	Yes
Stomach Ulcer	No	Yes
Eye Disease	No	Yes
Thyroid (overactive, underactive, goiter)	No	Yes
Kidney stones	No	Yes
Acute Infections	No	Yes
Venereal Disease	No	Yes
Hereditary defects	No	Yes
Bleeding tendency	No	Yes

Previous Hospitalizations/Surgeries:

_____
_____
_____
_____

Other Medical Problems: (Please list)

_____
_____
_____
_____
_____
_____

Medications: (name & dose)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergy to Meds: _____

Social History:

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Use of alcohol: Never ____ Rarely ____ Moderate ____ Daily ____

Use of tobacco: Never ____ Previously, but quit ____ Current packs/day _____

Family History:

	Age	Disease
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
	_____	_____
Spouse	_____	_____
Children	_____	_____
	_____	_____

Family History of: (please circle and state who)

Diabetes

Hypothyroidism Goiter

Hyperthyroidism

Reviewed by: _____ Date: _____

All other systems are negative