Oscar T. Ortiz, M.D. Ronald B. Villanueva, M.D. Francisco D. Cruz, M.D.

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

Other Medical Problems: (Please list)

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Medications: (name & dose)

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Previous Hospitalizations/Surgeries:

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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