

**MEDICAL RECORDS**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ OCCUPATION \_\_\_\_\_ DATE \_\_\_\_\_

REFERRING DOCTOR OR FAMILY DOCTOR \_\_\_\_\_

Please circle any of the following conditions or diseases that you have had or now have:

ANEMIA	ASTHMA	DIABETES	EMPHYSEMA	BLOOD CLOT
RHEUMATIC FEVER	TB	CANCER	VARICOSE VEINS	GOUT
VENEREAL DISEASE	STROKE	EPILEPSY	HEART ATTACK	ULCERS
THYROID TROUBLE	GLAUCOMA	PNEUMONIA	HIGH BLOOD PRESSURE	

If you have had or now have any other serious disease, please list them

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PLEASE CHECK 'YES OR NO' ON THE FOLLOWING QUESTIONS:

Difficulty speaking? _____	Yes No	Have you lost weight lately? _____	Yes No
Blurring vision? _____	Yes No	Have you had loss of appetite? _____	Yes No
Do you wear glasses? _____	Yes No	Have you ever been told you are a bleeder? _____	Yes No
Do you have frequent pain? _____	Yes No	Have you had any trouble with bleeding	
Are you hard of hearing? _____	Yes No	after a surgical procedure? _____	Yes No
Do you have frequent earaches? _____	Yes No		
Do you have frequent headaches? _____	Yes No	Please name the medications, if any, that you are	
Have you gained weight recently? _____	Yes No	now taking. Please list them: _____	
Do you have frequency dizzy spells? _____	Yes No	_____	
Do you wear dentures? _____	Yes No	_____	
Recent onset of hoarseness? _____	Yes No	_____	
Sinus trouble? _____	Yes No	Do you take blood thinners/aspirin or aspirin	
Do you have a productive cough? _____	Yes No	compounds? _____	Yes No
Pain in the chest? _____	Yes No	Are you allergic to sulfa? _____	Yes No
Difficulty breathing with exertion? _____	Yes No	Are you allergic to penicillin? _____	Yes No
Swelling of feet and ankles? _____	Yes No	other drugs: Please list them by name: _____	
High blood pressure? _____	Yes No	_____	
Palpitations of the heart? _____	Yes No	_____	
Heart murmur? _____	Yes No	_____	
Do you have heartburn? _____	Yes No	Please list all and any surgical procedures or injuries	
Other pains in the stomach? _____	Yes No	that you have had: _____	
Frequent constipation? _____	Yes No	_____	
Recent change in bowel habits? _____	Yes No	_____	
Do you have hemorrhoids? _____	Yes No	Please list all other hospitalizations you have had. _____	
Have you passed any blood in the stool? _____	Yes No	_____	
Have you ever had jaundice? _____	Yes No	_____	
Have you ever had gallbladder		List any complications that you have had with any	
Problems? _____	Yes No	surgical procedures: _____	
Indigestion from fried or fatty foods? _____	Yes No	_____	
Do you have rheumatism? _____	Yes No	_____	
Frequent or constant back pain? _____	Yes No	Have you ever smoked cigarettes? _____	Yes No
Pain shooting down the legs? _____	Yes No	Do you still smoke? _____	Yes No
Leg pain with walking? _____	Yes No	Do you drink alcoholic beverages? _____	Yes No
Have you had recurrent fevers or sweats		How much? _____ Daily _____ Weekly _____ Monthly	
at night? _____	Yes No		

FAMILY HISTORY OF: TB, CARCINOMA, HIGH BLOOD PRESSURE, RENAL DISEASE,  
 DIABETES OR HEART DISEASE: FATHER MOTHER BROTHER SISTER