Medical History:

Have you had any of the following? Please check:

Heart Attack ____	Stroke ____	High Blood Pressure ____	Peptic Ulcer Disease ____
Diabetes ____	Chest Pain ____	Shortness of Breath ____	Asthma ____
Cancer ____	Seizures ____	Urinary Tract Problems ____	Bleeding Tendency ____

Other: _____

Main reason for this visit: _____

Social History:

Do you smoke? ____ How much? ____ How many years? ____ Last Cigarette ____

Do you drink? ____ Beer/Wine? ____ Other Alcohol? ____ If so, about how much? ____

Are you presently being teated by another physician? ____ Who? _____

Surgical History:

Procedure	Date	Physician	Hospital

Family History:

Family Members	Living or Deceased	Age	Major Illnesses or Cause of Death
Father			
Mother			
Brothers/Sisters			
M F			
M F			
M F			
M F			
Spouse			
Sons/Daughters			
M F			
M F			
M F			
M F			