PATIENT'S NAME ______ DOB ______ DATE ______

G68(2)-0804

MEDICAL PROBLEMS *(Please check those that apply to you)*

DISEASE/CONDITION/PROBLEM	SPECIFY HOW LONG/WHEN/ETC.	DISEASE/CONDITION/PROBLEM	SPECIFY HOW LONG/WHEN/ETC.
☐ ARTHRITIS		☐ HEART DISEASE	
☐ ASTHMA		☐ HEARTBURN	
☐ BLOOD CLOTS		☐ HIGH BLOOD PRESSURE	
☐ CANCER (where)		☐ KIDNEY DISEASE/STONES	
☐ CARDIAC BYPASS SURGERY (when)		☐ SEIZURES	
☐ CIRCULATION PROBLEMS IN LEGS		☐ STROKE	
☐ DIABETES		☐ THYROID DISEASE	
☐ EMPHYSEMA		☐ VARICOSE VEINS	
☐ HEART ATTACK (when)		☐ OTHER	

FAMILY HISTORY *(Please complete to the best of your knowledge)*

RELATIVE	AGE	DISEASES/HEALTH PROBLEMS
MOTHER		
FATHER		
GRANDPARENTS		
SIBLINGS:		
BROTHER		
SISTER		

PAST SURGICAL HISTORY *(Please complete to the best of your knowledge)*

DATE	LOCATION	SURGERY	COMPLICATIONS	PHYSICIAN

LIST MOST RECENT *(Please complete to the best of your knowledge)*

TEST	DATE	ORDERING M.D.	TEST LOCATION
☐ BLOOD WORK			
☐ CARDIAC STRESS TEST			
☐ CAT SCAN			
☐ CHEST X-RAY			
☐ COLONOSCOPY			
☐ ECHO			
☐ EKG			
☐ ENDOSCOPY			
MALES ☐ PROSTATE TESTING OR EXAM			
FEMALES ☐ LAST MENSTRUAL CYCLE			
☐ MAMMOGRAM			
☐ PAP SMEAR			

☐ YES ☐ NO ANY CHANCE THAT YOU MAY BE PREGNANT?

☐ YES ☐ NO ARE YOU EXPERIENCING OR HAVE YOU HAD MENOPAUSE?