



Dr. John Crescitelli

Board Certified Family Medicine

**Past Medical History:** Please Check All That Apply Date (If Known)

Head Aches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes ( <i>Type 1 or Type 2</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid ( <i>Low or High</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Pulm. Emboli ( <i>Lung Clots</i> ) <input type="checkbox"/> DVT ( <i>Leg Clots</i> )			
Heart Burn, Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Coronary Disease <input type="checkbox"/> MI / Heart Attacks <input type="checkbox"/> Congestive Heart Failure			
<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Angina <input type="checkbox"/> Valve Disorder			
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gastrointestinal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hepatitis ( <i>A, B, C</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
HIV / AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chronic Wounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer ( <i>Type</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Urinary Tract Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
COPD( <i>Emphysema, Bronchitis</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chronic Fatigue Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Prostate Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Breast Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Erectile Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other	_____		