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MEDICAL HISTORY

Patient Name:_____Date:_____

MEDICAL HISTORY (If yes, check box & write past or present)

□ Headache _____ □ Hepatitis _____ □ Arthritis _____
□ Head injury _____ □ Appetite/Weight Change_____ □ Cancer _____
□ Loss of Consciousness_____ □ Thyroid Problems_____ □ Skin problems _____
□ Asthma _____ □ Diabetes _____ □ Vision problems _____
□ Shortness of breath_____ □ Kidney Disease _____ □ Hearing problems_____
□ Allergies/Hay fever_____ □ Urinary Problems _____ □ Polio _____
□ Heart problems _____ □ Seizures _____ □ Abnormal Lab Tests _____
□ High Blood Pressure_____ □ Withdrawal Seizures_____ □ Sexual Problems_____
□ GI disorder _____ □ Frequent Infections _____ □ Other _____
□ Constipation_____ □ Anemia _____ □ Other _____
□ Diarrhea_____ □ Allergies to medications- names and reactions: _____
_____

WOMEN ONLY

Currently Pregnant? □ Yes □ No Planning pregnancy? □ Yes_____ □ No _____
Regular Menstrual Cycles? □ Yes □ No Date of Last PAP? _____

MEN ONLY

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? □ Yes □ No
How often does this occur? □ Frequently □ Sometimes □ Rarely

HABITS

□ Smoke: Packs Daily_____ □ Coffee: Cups daily: _____ □ Sleep: Difficulty falling asleep _____
How long? _____ Other caffeine _____ Difficulty staying asleep _____
Tried stopping?_____ □ Alcohol/Drugs: Type: _____ Snoring _____
□ Exercise: What kind _____ Amount daily:_____ Early morning awakening _____
Minutes per day_____ Amount Weekly:_____ □ Special Diet: _____
Days per week_____

HOSPITALIZATION OR SURGERY

Reason(s):_____ Date: _____
Reason(s):_____ Date: _____