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**MEDICAL HISTORY**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Date of most recent physical examination. \_\_\_\_\_

<b>Current Medications</b>	<b>Dosage</b>	<b>Taken for</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

	<b>Have you ever been treated for any of the following?</b>		<b>COMMENTS</b>	<b>Has anyone in your family been treated for?</b>	
	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Heart Disease					
High Blood Pressure					
Stroke					
Diabetes					
Arthritis					
Parkinson's					
Cataracts/other eye problems					
Glaucoma					
Hearing Problems					
Lung Disease					
Skin Diseases					
Ulcers					
Colitis					
Growths / Cancer					
Other Major Illnesses					
Major Operations					
Sexually Transmitted Diseases					
Kidney Disease					
Liver Disease					
Gynecologic Problems					
Psychiatric Disorders					
Hospitalizations					

<b>Have you had?</b>	<b>Has anyone in your family had?</b>				
Blackouts					
Convulsions or Seizures					
Headaches					
Tremors					
Dizziness					
Forgetfulness					
Major Weight Loss/ Gain					

<b>Do you have a history of:</b>	<b>Does anyone in your family have a history of:</b>				
Drug Abuse					
Alcohol Abuse					

**BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS**  
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