MEDICATIONS (Prescription, Over-the-Counter, Vitamins, Herbal, etc.)

Drug Name	*Dose*	*Drug Name*	*Dose*
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

ALLERGIES TO MEDICATIONS: ____

PRIOR SURGERIES: *DATE:*

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS: *(Circle if you have had problems with or are presently complaining of any of the ff:*

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain/Tightness
6. Shortness of Breath
7. Swollen ankles
8. Palpitations
9. Light headedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. TB
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney disease
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout

Others: ____

____

GYNECOLOGIC & OBSTETRIC HISTORY *(Women Only)*

Periods: *Age at Onset:* __________ *Frequency:* ______________ *Length of Periods:* _______________

Pregnancies: *Total:* ____________ *Births:* ______________ *Miscarriages:* _________________

Prolonged abnormal bleeding