

PATIENT HISTORY

NAME: _____

REFERRED BY: _____

AGE: _____

OCCUPATION: _____

What is the main reason for this visit?

MEDICAL ILLNESS:

PREVIOUS SURGERY:

MEDICATIONS:

ALLERGIES:

HABITS: SMOKING:

ALCOHOL:

MEDICAL ILLNESSES IN FAMILY?

Do you have problems with:

_____ Diabetes

_____ Epilepsy

_____ High Blood Pressure

_____ Arthritis

_____ Heart Disease

_____ Anemia

_____ Lung Disease

_____ Stroke

_____ Cancer

_____ Thyroid Disease

_____ Kidney Disease

_____ Other

I authorize a report of my evaluation to be sent to my referring physician and/or family physician and/or other physicians involved in my health care.

PATIENT SIGNATURE

DATE