MEDICAL HISTORY

PATIENT NAME ___________________________

Physician's Name: _______________________________Phone #:______________

Date of last visit with M.D.:____________ Date of last Hospital stay:____________

Are you under a physician's care now? Y N Have you had any serious illnesses or operations? Y N

If yes, describe____

(Women) Are you pregnant? Y N Nursing? Y N Taking Birth Control? Y N

Do you have, or have you had, any of the following? (Please check box)

Heart & Cardiovascular: ☐ High Blood Pressure ☐ Heart Attack ☐ Heart Murmur
☐ Bruise Easily ☐ Low Blood Pressure ☐ Stroke ☐ Swelling of limb or ankles
☐ Chest Pain ☐ Easily Winded ☐ Heart Valve Sx. ☐ Congenital Heart Disorder
☐ Irregular Heartbeat ☐ PE or DVT (blood clots) ☐ A-Fib ☐ Blood Thinners

Lung & Respiratory: ☐ Asthma ☐ Persistent Cough ☐ Emphysema or COPD
☐ Seasonal Allergy ☐ Tuberculosis ☐ Bronchitis ☐ Tobacco Use; ____ packs a day

Neurologic problems: ☐ Fibromayalgia ☐ Seizures ☐ Shingles
☐ Fainting/Dizziness ☐ Frequent Headaches ☐ Jaw Pain ☐ Alzheimer's or Dementia
☐ Back Problems ☐ Chronic Pain Management

Infectious Diseases: ☐ AIDS/HIV ☐ Hepatitis A, B, C ☐ Herpes
☐ Rheumatic Fever ☐ Scarlet Fever ☐ Venereal Disease ☐ Cold Sores/Fever Blisters

Gastro-Intestinal problems: ☐ Reflux or GERD ☐ Ulcers ☐ Frequent Diarrhea

Endocrine problems: ☐ Thyroid Disease ☐ Diabetes ☐ Prednisone or Cortisone Tx

Cancer: ☐ Chemotherapy ☐ Radiation Tx ☐ Cancer Surgery

Psychiatric conditions: ☐ Anxiety or Depression ☐ PTSD ☐ Under psychiatric care?
☐ Alcoholism ☐ Drug Addiction ☐ Rehab? ☐ Personality Disorder

Blood conditions: ☐ Anemia ☐ Hemophilia ☐ Leukemia

OTHER: ☐ Osteo-arhtritis ☐ Joint Replacement ☐ Rheumatoid Arthritis
☐ Skin disease ☐ Artificial Joints ☐ Kidney Disease ☐ Liver Disease
☐ Glaucoma ☐ Jaundice ☐ Hypoglycemia ☐ Excessive Thirst
☐ Osteoporosis ☐ Osteopenia ☐ Osteoporosis Medications (Fosamax, Actonel, etc)

MEDICATIONS: (list all current meds, including non-prescription) ______________________________

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____

ALLERGIES to medications: ____

Pharmacy Name: __________________________Phone# _________________Location ____________________

Do you have questions for Dr. Auzins that you wish to ask in private? Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr. Auzins of any changes in medical status.

____ ___________________

Signature of Patient, Parent, or Guardian Date