

For Office Use Only	
Patient #	

Yes No Do Yes No Do Yes No Do Yes No Pa PERSONAL Do you have o If yes, please o Anemi ADD/A Anxiet Arthriti Asthm Back F Blood Blood	o you take regular med evernight Hospitalization ast Surgeries. Indicate MEDICAL HISTOR or have you ever had any check and explain be oil / Drug dependency onal Allergies ia / Blood disease ADHD ty / Depression iis	es (includication dication dic	ns (include birth control, vitamins, son ER). Indicate reason and dates: of surgery and date: following? Hypoglycemia Kidney Problems Liver Problems Malaria	FAM Does follow	MILY MEDICAL HISTORY anyone in your immediate family have wing conditions? (IE MOTHER, FATHER, SI DPARENTS) Alcohol / Drug / Substance Dependency Anemia/Blood / Clotting Problem	e any of the
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Arthriti Asthm Back F Blood Blood Bronch	is				Arthritis	
Asthm Back F Blood Blood Bronch			Mononucleosis		Asthma / Allergies	
Back F Blood Blood Bronch			Musculoskeletal Problems		Cancer Specify:	
Blood Blood Bronch	na		Neurological Problems		Diabetes	
Blood Bronch	Problems		Pregnancy , history of		Eating Disorders	
Bronch	Clots (legs, lungs)		Psychological Disorders		Epilepsy, Seizures	
_	Transfusions		Sexually Transmitted Infection		Gastrointestinal Problems	
Cance	hitis / Pneumonia		Strep Throat		Heart Attack / Stroke	
	er		Skin Condition		High Blood Pressure	
Concu	ussion / Head Injury		Thyroid Problems		High Cholesterol	
Diabet	tes		Tuberculosis / Positive PPD		Kidney Disease	
Ear Pr	roblems		TMJ (jaw problems)		Liver Disease	
	Disorders		Urinary Tract Infections		Neurological Problems	
Epilep	sy/Seizures				Psychological Disorders	
Eye / \	Vision Problems				Thyroid Problems	
	res / History of Injury				Tuberculosis	
	ointestinal Problems					
Heada						
	Problem / Murmur	1	Other:		Other:	
	Blood Pressure	_				
High C	Cholesterol					