Medical History

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____

Last First M. I.

Age:___________ Sex: ❑ F ❑ M

How did you hear about this clinic?
Radio WATE WBIR

Internet: Ad Website Friend MD Other:

Briefly describe your symptoms:

Names of other practitioners you have seen for this problem, other treatments for problem, if any:

Previous surgeries and dates:

Medications:

Are you currently taking Methotrexate? Yes No

Serious medical problems in family members:

Allergies:

Have you ever had radiation therapy? Yes No

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Lupus
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Scleroderma

Do you have any Autoimmune disorders?

____

Patient Signature:____ Date:____________________