COMPREHENSIVE PATIENT MEDICAL HISTORY

Are/Have you being/been treated for any of the following:

▢ Alzheimer's	▢ Eye Problem	▢ Keloid/Thick Scar	▢ Psychiatric Disorder
▢ Anemia	▢ Gout	▢ Kidney Disease	▢ Raynaud Disease
▢ Arthritis	▢ Headaches	▢ Liver Disease	▢ Rheumatic Fever
▢ Asthma	▢ Hearing/Ear Problem	▢ Lung Disorder	▢ Sciatica
▢ Cancer	▢ Heart Attack	▢ Lyme's Disease	▢ Stomach Ulcer
▢ Chronic Light Stool	▢ Heart Condition	▢ Nerve Disorder	▢ Stroke
▢ Dark Urine	▢ Hepatitis	▢ Osteoporosis	▢ Tuberculosis
▢ Diabetes	▢ High Blood Pressure	▢ Phlebitis	▢ Thyroid Problem
▢ Epilepsy	▢ HIV	▢ Poor Circulation	▢ **NONE OF THESE**

List of Allergies - Skin or Other Severe Reactions

Are you allergic to:	YES	NO	If yes, what happens?
Penicillin	▢	▢	
Other Antibiotic	▢	▢	
Asprin, Advil, Aleve	▢	▢	
Latex	▢	▢	
Novocaine	▢	▢	
Sulfa	▢	▢	
Adhesive Tape	▢	▢	
Pain Medicine	▢	▢	
Shrimp/Iodine	▢	▢	
Tylenol	▢	▢	
Other	▢	▢	

List of Medications:		**Family Members Who Have Had:**	
Medicine:	**Treatment for:**	Diabetes	
		Arthritis	
		Stroke	
		Gout	
		Foot Issues	
		Heart Attack	
		Cancer	
		High Blood Pressure	

Are you currently pregnant?	▢ Yes	Due date:				▢ No
Are you slow to heal?	▢ Yes	Explain:				▢ No
Any abnormal bleeding?	▢ Yes	Explain:				▢ No
Have you had a pneumonia shot?	▢ Yes	When?				▢ No
Have you had a flu shot?	▢ Yes	When?				▢ No
Have you had a COVID-19 shot?	▢ Yes	When?				▢ No
Have/Do you smoke(d)?	▢ Yes	▢ < 1 pk	▢ < 2 pks	▢ 2+ pks		▢ No
How long did/have you smoke(d)?		▢ Quit	▢ 1-5 yrs	▢ 5-10 yrs	▢ 10+ yrs	
Do you drink alcohol?	▢ Yes	▢ Rare	▢ Moderate	▢ Daily		▢ No
Do you take coumadin?	▢ Yes	Since?				▢ No
Do you have diabetes?	▢ Yes	Since?				▢ No
Do you have any vascular grafts?	▢ Yes	When?				▢ No
Do you have joint implants?	▢ Yes	Explain:				▢ No
Have you had any serious illness?	▢ Yes	Explain:				▢ No
Have you had surgery?	▢ Yes	Explain:				▢ No