MEDICAL HISTORY UPDATE

Name_____Birthdate_____Date_____

Referring Physician_____

Primary Care Physician, Internist or Endocrinologist_____

Have you been diagnosed with any of the following?

	Yes	No	Date of Onset
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Lung Disease	☐	☐	_____
Stroke	☐	☐	_____
Cancer	☐	☐	_____
Migraine	☐	☐	_____

Please list any other conditions for which you have been under medical care.

_____

_____

List all medications including vitamins & herbal supplements.
Any changes to medications since last visit? Yes ☐ No ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Are you allergic to any medications? Yes ☐ No ☐
If YES, list medications _____

Are you allergic to Latex? Yes ☐ No ☐
Any additional surgeries since last visit, including eye surgeries, and date of each

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Any Problems with anesthetics (Local or General)? Yes ☐ No ☐
If YES, please describe _____

Have you had a MRI or CT Scan? Yes ☐ No ☐
If YES, what were the results _____

History Reviewed.
Date _____ M.D. Signature Required _____