14107 Cortez Blvd
Brooksville, FL 34613
(352)549-9962 – Phone
(352)549-9963 – Fax

Patient Name: _____

MEDICAL HISTORY

Please check YES or NO if you HAVE BEEN DIAGNOSED with ANY of these conditions in your past:

Common Conditions	YES	NO
Hypertension		
Type 1 Diabetes		
Type 2 Diabetes		
High Cholesterol		
Osteoporosis		
Depression		
Cancer		
Have you ever been diagnosed with Cancer?		
TYPE:		
Hearing/Eyes/ENT		
Glaucoma		
Macular Degeneration		
Diabetic Retinopathy		
Hearing Loss		
Ear Infections		
Sinusitis Chronic		
Respiratory		
Asthma		
COPD		
Chronic Bronchitis		
Interstitial lung disease		
Emphysema		
Pulmonary Embolism		
Obstructive Sleep Apnea		
Tuberculosis exposure		
Cardiology		
Atrial Fibrillation		
Pacemaker / Date of Placement:_____		
Angina		
CHF (Congestive Heart Failure)		
Heart Attack (myocardial infarction)		
Aortic Valve Disorder		
Mitral Valve Disorder		
Neurology		
Alzheimer's Disease		
Parkinson's Disease		
Seizures		
Stroke - Area Affected: _____		
Gail Instability with falls		
Peripheral Neuropathy		
TIAs		
Migraine Headaches		
Multiple Sclerosis		
Trigeminal Neuralgia		
Psychiatric		
Alcoholism		
ADD/ADHD		
Bipolar Disorder		
Bulimia		
Drug Abuse		

Common Conditions	YES	NO
Hypothyroidism		
Coronary Artery Disease		
Congestive Heart Failure		
COPD		
Osteoarthritis (generalized)		
Anxiety		
Gastrointestinal		
Acid Reflux		
Barrett's Esophagus		
Peptic Ulcer Disease		
Ulcerative Colitis		
Irritable bowel syndrome		
Diverticulosis		
H/O Colon Cancer		
Urinary/Renal		
Polycystic kidney disease		
Nephrolithiasis		
Urinary Incontinence		
History of UTI's		
Musculoskeletal		
Arthritis - Location(s):		
Osteopenia/Osteoporosis		
Lumbar disc disease		
Restless Leg Syndrome		
Rotator cuff syndrome		
Sciatica		
Spinal Stenosis of:		
Cervical Spine		
Lumbar Spine		
H/O compression - Fractures		
Rheumatology		
Gouty Arthritis		
Fibromyalgia		
SLE		
Rheumatoid Arthritis		
Lupus Erythematosus		
Hematology		
B-12 deficiency anemia		
Iron deficiency anemia		
Myelodysplastic Syndrome		
Anemia		
Endocrine		
Grave's Disease		
Hyperthyroidism		
Hypothyroidism		
Thyroid Nodule		
Skin		
Basal Cell Carcinoma		
Squamous Cell Carcinoma		
Melanoma		
Psoriasis		
Rosacea		

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MEDICAL HISTORY PART II

Please check YES or NO if you HAVE BEEN DIAGNOSED with ANY of these conditions in your past:

Women Reproductive	YES	NO	Male Reproductive	YES	NO
Bladder suspension surgery			Erectile Dysfunction		
Fibrocystic breast disease			Prostate Enlargement		
Hysterectomy			Hypogonadism		
H/O of cervical or endometrial cancer			H/O of prostate cancer		
Polycystic ovarian disease			Urological implant		
Uterine Prolapse			Other:		

SURGICAL HISTORY

Please check YES or NO if you HAD with ANY of these procedures in your past:

General	YES	NO	Women	YES	NO
Aortic aneurysm repair			Breast Implants		
Aortic Valve Repair			Breast reduction		
Appendix removal (Appendectomy)			C-Section		
Bariatric surgery			Endometrial biopsy		
Carpal tunnel release			Hysterectomy : Partial Complete		
Cataract surgery : Right Left			Lumpectomy : Right Breast Left Breast		
Colon resection (Colectomy)			Mastectomy : Right Breast Left Breast		
Coronary artery - Bypass surgery			**Men**		
Fracture repair – Where?			Prostate Biopsy		
Gallbladder removal (Cholecystectomy)			Prostate Removal		
Gastric Bypass surgery			**Joint Replacement**		
Hemorrhoid removal (Hemorrhoidectomy)			Left Hip		
Hernia Repair : Femoral Inguinal			Right Hip		
Kidney Removal: (Nephrectomy) Right Left			Left Knee		
Mitral valve replacement			Right Knee		
Parathyroid removal (Parathyroidectomy)			Left Shoulder		
Pacemaker placement			Right Shoulder		
Polyp Removal (Polypectomy)			Right Elbow		
Septum and nose repair			Left Elbow		
Spinal surgery – Where?			**Biopsy**		
Type:			Bone Marrow		
Thyroid removal (Thyroidectomy)			Liver		
Tonsillectomy			Skin		
Varicose vein surgery			Mass Excision - Where?		

Do you smoke? Y/N: _____

Please list any other items/procedures not listed:

Please list all medications taken (prescription and OTC):