MEDICAL HISTORY

Reason for Visit Today: ____

Symptoms and for how long: ____

Have you been diagnosed and/or treated for: (Please answer each one)

Alcoholism	Yes	No	Hepatitis A,B,C	Yes	No
Anemia	Yes	No	Heart Attack	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Artificial Joint	Yes	No	HIV+	Yes	No
Asthma	Yes	No	Keloids or scarring	Yes	No
Anxiety Disorder	Yes	No	Kidney Disease	Yes	No
Blood Disorder	Yes	No	Liver Disease	Yes	No
Bowel Disorder	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	Prolonged Bleeding	Yes	No
Depression	Yes	No	Psychiatric Treatment	Yes	No
Diabetes	Yes	No	Radiation Treatment	Yes	No
Drug Addiction	Yes	No	Skin cancer	Yes	No
Allergies	Yes	No	Stroke	Yes	No
Heart Surgery	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Ulcers	Yes	No

If you answered yes to any of the above, please explain: ____

____

Other current or previous medical conditions not listed above: ____

____

List previous operations with approximate dates: ____

____

Family history: ____

____

Please list all medications & supplements including dosages: ____

____

List any drug & food allergies: ____

Do you use tobacco products? **Yes** **No** If so, what type ____________________ and how often____________________

Alcohol Use (circle one): **Socially** / **Rarely** / **Daily** / **Never** Do you use cocaine? **Yes** **No** Marijuana? **Yes** **No**

Patient's Height _________ Weight _________ Bra Size _________ Date of last mammogram: ______________

OFFICE USE ONLY

Positive Findings: ____

Impression: ____

Donen Davis, J.D., M.D.: ____________________________________ *Date:* ______________