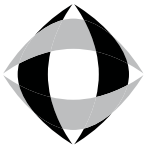
Medical History



Drs. Campbell Cunningham
Taylor & Haun

Your Information

1. Patient Name _____ Chart# _____ Today's Date: _____

Medical History

2. Primary care doctor: _____ Tel: _____
3. Do you now, or have you ever had: Diagnosis date:

a. Diabetes ..... Yes ☐ No ☐ _____
Treatment: diet control ☐ oral agents ☐ insulin ☐ other ☐ _____
Medical complication: kidney ☐ vascular ☐ eye ☐ other ☐ _____
b. Heart attack ..... Yes ☐ No ☐ _____
Angina or chest pain ..... Yes ☐ No ☐ _____
Heart failure ..... Yes ☐ No ☐ _____
Irregular or rapid heart beat ..... Yes ☐ No ☐ _____
Cardiac pacemaker inserted ..... Yes ☐ No ☐ _____
c. High blood pressure ..... Yes ☐ No ☐ _____
d. Stroke or TIA ..... Yes ☐ No ☐ _____
e. Anemia ..... Yes ☐ No ☐ _____
f. Asthma ..... Yes ☐ No ☐ _____
Emphysema and/or bronchitis ..... Yes ☐ No ☐ _____
Pneumonia ..... Yes ☐ No ☐ _____
Tuberculosis ..... Yes ☐ No ☐ _____
g. Liver disease or jaundice ..... Yes ☐ No ☐ _____
h. Stomach or duodenal ulcer ..... Yes ☐ No ☐ _____
i. Kidney stones / other kidney disease ..... Yes ☐ No ☐ _____
j. Arthritis: rheumatoid ☐ osteo ☐ ..... Yes ☐ No ☐ _____
k. Cancer or tumor ..... Yes ☐ No ☐ _____
Type: _____
Treatment: _____
l. Thyroid disease: underactive ☐ overactive ☐ ..... Yes ☐ No ☐ _____
Treatment: _____
m. Migraine ..... Yes ☐ No ☐ _____
n. Blood clot in legs ..... Yes ☐ No ☐ _____
o. Bleeding disorders ..... Yes ☐ No ☐ _____
p. Transfusions of blood or plasma ..... Yes ☐ No ☐ _____
q. HIV positive, AIDS ..... Yes ☐ No ☐ _____
r. Other medical problems ..... Yes ☐ No ☐ _____
Please describe: _____
_____

4. Are you allergic to any medications or foods? ..... Yes ☐ No ☐ _____
If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below: _____

Eye medication(s):

Name	Dose	Frequency	Eye

All other medication(s):

Name	Dose	Frequency