Dr. Scott Yarmark Dr. William Dickerman

MEDICAL HISTORY

PLEASE FILL OUT AS MUCH INFORMATION AS POSSIBLE

Allergies to Medications: Yes No

X-ray Dyes, or other Substances (If yes, please list the name of medication and ***type of reaction***):

_____

_____

_____

Medications (Prescription, Over-the-counter, Vitamins, Herbs, Etc.) Drug Name and Dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy: _____ Phone #: _____ - _____ -_____

Past Medical History & Review of Symptoms:

Please ***circle*** if you have had problems with or are presently experiencing any of the following:

High Blood Pressure Arthritis Kidney Stones Difficulty urinating Diabetes (TYPE 1 or 2) CVA (stroke)

T.B Indigestion Cancer (Type): _____ Hepatitis A, B, or C Low Back Problems Hay Fever

Heart Disease COPD Skin Diseases Headache/Migraines Chest pain/tightness Fracture (type/where):_____

Blood Disorders Ulcers Shortness of Breath Blood in Stool Venereal Diseases Persistent Cough

DVT (blood clot) Head or Neck radiation Anxiety Pneumonia Palpitations Change in bowl habits

Depression Thyroid Disease (hypo/hyper) Lightheadedness Weight Gain Anemia Hepatitis/Jaundice

Frequent Urination Hemorrhoids Alcohol Abuse Bronchitis Rheumatic Fever Gall Bladder Disease

Drug Abuse Gout Asthma Colitis Other: _____

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MEDICAL HISTORY

Do you smoke? Yes No If yes, how many packs/day? _____

Do you drink alcohol? Yes No If yes, how much/week? _____

Immunization History – have you had:

Hepatitis B: Yes No When? _____

Adacel Vaccine (Tetanus): Yes No When? _____

Pneumonia Vaccine: Yes No When? _____

Flu Vaccine: Yes No When? _____

MMR Vaccine: Yes No When? _____

Shingles Vaccine: Yes No When? _____

Other: Yes No When? _____

Family History: Has any member of your family (including parents, grandparents, siblings and children) ever had the following…PLEASE STATE WHICH SIDE OF THE FAMILY ie. MATERNAL/PATERNAL.

ILLNESS:	WHICH FAMILY MEMBER(S)	AGE WHEN DIAGNOSED
Cancer(describe type):		
Hypertension (High Blood Pressure):		
Heart Disease:		
Diabetes (type 1 or 2):		
Stroke:		
Mental Disease (anxiety, depression, etc.)		
Drug or Alcohol Addiction:		
Glaucoma:		
Bleeding Diseases:		
Other:		

Please List & Supply the dates of Operations and Hospitalization: