

**GEORGE P. CHATSON, M.D.**

**PATIENT MEDICAL HISTORY FORM**

Date \_\_\_\_\_

Name \_\_\_\_\_

Reason for consultation \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Tel # \_\_\_\_\_

Primary Care Physician Address \_\_\_\_\_

In case of emergency please notify \_\_\_\_\_

Tel # \_\_\_\_\_ Relationship \_\_\_\_\_

Is this visit a result of an accident or injury? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, date of injury \_\_\_\_\_

If yes, please specify details \_\_\_\_\_

Attorney Name (if applicable) \_\_\_\_\_ Tel # \_\_\_\_\_

Attorney Address \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?**

**Please check if applicable**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Circulation Problems  | <input type="checkbox"/> Joint Disease    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Bruise Easily         | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Intestinal Disease    | <input type="checkbox"/> Liver Disease    |

Please describe all other medical conditions \_\_\_\_\_

Please list past surgeries \_\_\_\_\_

Please list your medications and prescribed dosages. Include herbal, diet, vitamin supplements and any OTC medications \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you have any allergies to medication/food? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: Drug \_\_\_\_\_ Reaction \_\_\_\_\_  
Drug \_\_\_\_\_ Reaction \_\_\_\_\_  
Food \_\_\_\_\_ Reaction \_\_\_\_\_  
Food \_\_\_\_\_ Reaction \_\_\_\_\_

Please list family history of medical problems \_\_\_\_\_