NYOS Medical History (4)

Please check all that apply:

- High blood pressure _______
- Coronary artery disease_________
- Congestive heart failure_________
- Heart attack______ Family History______
- Stroke_______ Family History______
- Cancer_______ Family History______
- Asthma_______
- Diabetes_______ Family History______
- Emphysema_______

Pneumonia_______
Peptic Ulcer Disease______
Cirrhosis______
Blood Clots______
Gout______
Osteoarthritis______ Family History______
Rheumatoid Arthritis________
Osteoporosis________
Other________________________________

Have you had any surgeries in the past? Please list and give dates:

Procedure____ Date_________________

Procedure____ Date_________________

Procedure____ Date_________________

Do you have any allergies to medications if so please list: _________________________________

Please list all medications taken daily:

Name: ________________Dose:______________ Name: _______________ Dose: ______________

Name: ________________Dose:______________ Name: _______________ Dose: ______________

Name: _______________ Dose: ______________ Name: _______________ Dose: ______________

Recent Health Review of Systems: Just mark an(X) next to what applies

Weight gain	Vision changes	Chest pain
Weight loss	Hearing loss	abdominal pain
Appetite loss	Tooth or gum disease	Diabetes
Malaise	Skin Changes	steroid use
Fever	Urinary Problems	Depression
Vomiting	Gynecologist problems	personal loss
Diarrhea	Enlarged glands	psychiatric problems
Headache	Breast lumps	other: ______________________
Seizures	Difficulty breathing	other: ______________________