Medical History

Annette LaCasse, D.O., P.C.

Today's Date____/____/_____

Name:(Print) _____ Date of Birth____/____/_____

Reason for today's visit (chief complaint):

_____

_____

_____

Please circle either "C" or "P" to let us know any problems you have, or have had in the past

***C= Current**

***P= Past**

General

C P Allergies
C P Tobacco Use
C P Alcohol Use
C P IV Drug Use
C P Cosmetic Surgery
C P Ear Problems
C P Fainting
C P Head Injury

Pulmonary

C P Asthma
C P Chronic Bronchitis
C P Emphysema
C P Pneumonia
C P Exposure to TB
C P Shortness of Breath
C P Other Lung Disease
C P Lower Extremity Edema
C P Palpitations

Gastrointestinal

C P Stomach Ulcers
C P Disease of the Colon
C P Abdominal Pain
C P Hemorrhoids
C P Liver Disease

Skin & Hair

C P Reaction to Local Anesthetic
C P Reaction to Substances Applied to Skin
C P **Melanoma**
C P Non-Melanoma Skin Cancer
C P Abnormal Skin Healing
C P Herpes Infection

Cardiovascular

C P High Blood Pressure
C P Heart Attack
C P Angina/Chest Pain
C P Congestive Heart Failure
C P Other Heart Disease
C P Stroke
C P High Cholesterol

Infectious Disease

C P Hepatitis A__ B__ C__
C P HIV
C P MRSA

Neurology

C P Seizures/Epilepsy
C P Numbness
C P Dizziness
C P Migraines

Psychiatric

C P Depression
C P Anxiety

Endocrinology

C P Diabetes
C P Thyroid Disease

Hematology

C P Blood Transfusions
C P Bleeding/Clotting disorder
C P Anemia

Musculoskeletal

C P Osteoporosis
C P Broken Bones/Accidents
C P Arthritis
C P Back Problems
C P Muscle Weakness
C P Hiatal Hernia
C P Gout

Urinary

C P Kidney Disease
C P Bladder Problems
C P Prostate Problems

Is there anything else we should know about your health?_____

_____

Women:

Are you pregnant? Yes ___ No ___ Could you be pregnant? Yes___ No___

Planning to become pregnant? Yes ___ No ___

Abnormal periods? Yes__ No__ Date of last period: ____/____/_____

Excessive facial and/or body hair? Yes___ No___

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Family History: (Past family and social history)

Mother: ___ Living ___ Deceased ___ Age
Father: ___ Living ___ Deceased ___ Age

Check the following medical conditions that have occurred in your **family**:

Disease	Mother	Father	Blood Relative
Malignant Melanoma	_____	_____	_____
Non-Melanoma Skin Cancer	_____	_____	_____
Allergies	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Eczema	_____	_____	_____
Hay fever	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Lung Disease	_____	_____	_____
Psoriasis	_____	_____	_____
Tuberculosis	_____	_____	_____
Other Cancers	_____	_____	_____

Is there any other family history you think we should know about?_____
_____
_____