- LEESBURG -
MEDICAL CLINIC

Name (Last, First, Middle)	Date of Birth	Race or ethnicity or N/A	Sex (M/F)
Social Security Number	_ _ _ - _ _ - _ _ _ _		

MEDICAL HISTORY

Include date of diagnosis	Yes	No		Yes	No		Yes	No
Diabetes: type I or II			Thyroid:			Severe skin Disorder:		
Diabetic Neuropathy			Difficulty Breathing:			Epilepsy/Seizures:		
Diabetic Retinopathy			Asthma:			Insomnia:		
Diabetic Nephropathy			Heart Murmur:			Excessive Weight Gain/Loss:		
Rheumatoid Arthritis			Chest Pain/Pressure:			Coronary Artery Disease:		
High Blood Pressure			Heart Attack/Angina:			Bone Fractures:		
High Cholesterol			Constipation:			Other:		
Hypoglycemia			Stomach Ulcers:			**FEMALES ONLY**		
Cancer			Rectal bleeding:			Currently Pregnant:		
Eye Conditions			Prolonged Diarrhea:			Child Bearing Potential?		
Dizziness			Hemorrhoids			Last Normal Menstrual period:		
Headaches			Kidney Disease			Vaginal East Infections?		

FAMILY HISTORY	**Age**	**Significant Medical History**	**Deceased – Cause of death**
Father			
Mother			
Brother(s)			
Sister (s)			

GENERAL HISTORY	**Yes**	**No**				
Do you smoke?			If "Yes", How often?		If past smoker, when did quit?	
Do you drink alcohol?			If "Yes", How much?		How frequently?	
Any substance abuse?			If "Yes: Which substance?		How frequently?	

CURRENT MEDICATIONS & START DATE		**SURGICAL HISTORY**

ALLERGIES TO MEDICATIONS

Name of Medication	Type of reaction	Name of Medication	Type of reaction

Thereby certify that the information provided above by me, is completed and true to the best of my knowledge

Signature of patient/Guardian_____ Date_____

Signature of MD or ANP _____ Date _____

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