PATIENT MEDICAL HISTORY

NAME: _____ **AGE:** _____ **DATE:** _____

REFERRED BY: _____

REASON FOR REFERRAL: _____

List Tests done for this condition by your Family doctor _____

Do you have any of the following conditions: (please circle)

1. Heart disease -	Angina	High blood pressure	Arrhythmia	Valve disease
	Murmurs	Heart failure		
2. Lung disease -	Asthma	Emphysema	Bronchitis	Sleep apnea
3. Gastrointestinal -	Heartburn	Difficulty swallowing	Vomiting	Constipation
	Rectal bleeding	Diarrhea	Abdominal pain	
	Hepatitis	Gallstones	Cirrhosis 0f liver	
4. Neurological -	Stroke	MS	Parkinson's disease	Seizures
5. Musculoskeletal -	Arthritis	Osteoporosis	Fibromyalgia	
6. Endocrine -	Diabetes	Thyroid disease	High Cholesterol	

Other conditions not mentioned above: _____

List all previous surgeries: _____

List all your medications:_____

_____

Are you allergic to any drugs? _____

Family History - Are you: Single Married Divorced Separated Widowed

Do you: Smoke? Y N Cigarettes per day _____

Drink alcohol? Y N How much? _____

Do any diseases run in your family? _____

Please note that it is our office policy to contact patients only if results of tests ordered by Dr. Bali are abnormal. You may call our office to get your results during office hours.

Signature: _____ Date: _____