

Patient Medical History

C. William Doubleday, M.D.

Please print clearly

Name _____ Date _____

Reason for today's visit: _____

Referred by: _____ (friend, family member, physician)

Do you need authorization for today's visit from your Primary Care Physician? _____

Current medications (prescription, non-prescription, vitamins) _____

Medication allergies: _____

| HAVE YOU EVER HAD OR PRESENTLY HAVE : | Y | N | DATE |
|---------------------------------------|---|---|------|
| Heart problems | | | |
| Lung problems | | | |
| Liver problems | | | |
| Rheumatic Fever | | | |
| Hepatitis (Yellow Jaundice) | | | |
| High blood pressure | | | |
| Tuberculosis | | | |
| Asthma | | | |
| Hayfever | | | |
| Eczema | | | |
| Diabetes | | | |
| Thyroid disease | | | |
| Sensitivity to light | | | |
| Lupus Erythematosus | | | |
| Seizures or epilepsy | | | |
| Cancer of any type | | | |
| Anemia or blood problems | | | |
| Nervous or mental problems | | | |
| Recent weight gain or loss | | | |
| Blood transfusion | | | |
| Stomach or duodenal ulcer | | | |
| Pregnancy at present time | | | |

Release of Medical Information

I hereby authorize the release of medical information necessary to process insurance claims and do also authorize the payment of medical benefits to Dr. Doubleday for medical treatment or services rendered.

Signed (patient or legal guardian) _____