

**Advanced Physical Medicine
Health History**

Patient Name: _____

Date: _____

Please complete the following in detail and bring to your appointment.

Past Medical History

AIDS	Congestive heart failure	Hepatitis	Liver disease
Alcoholism	Diabetes	HIV positive	Mental illness
Arthritis	Epilepsy	Hypercholesterolemia	Migraine
Asthma	Gout	Hypertension	Neurologic
Bronchitis	Headaches	Intestinal disease	Seizure
Blood disease (sickle cell)	Heart disease	Kidney disease	Stroke
Cancer			
Other _____			

Past Surgical History

Family History

List conditions that family members are known to have or have had.

Medications

List medications you are currently taking.

Allergies

I consent to medical care including routine procedures, examinations, test, immunizations, region and local anesthesia, and other treatment by the physician. I consent to the testing and disposal of specimens, blood, urine, and other bodily fluids, and tissues. I understand that an HIV (human immunodeficiency virus) test may be done upon me without my further consent if a doctor, health professional, or employee sustains a percutaneous mucous membrane or open wound exposure to my blood or other bodily fluid.

I certify that the above information is correct and true to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date