**Medical History:**

Food or Drug allergies and reaction: _____
_____
Current medication (new patients-bring ALL medications you are presently taking from all physicians):
_____
_____
_____
Medical Problems currently being treated: _____
_____
Hospitalizations: _____
_____
Females; Number of pregnancies: _____

Surgical Histories: _____
_____

Childhood illnesses: Rheumatic Fever__ Mumps__ Measles__ Rubella__ Polio__ Diphtheria__ Tetanus__
Whooping cough__ Autism/Asperger's Syndrome__ Cancer__ Chickenpox__ Diabetes__ Down's syndrome__
Duchenne Muscular dystrophy__ ADD__ ADHD__ Mono__
Transfusions: _____
Immunization Record Available? _____
History of:
Headaches_____ Lactose Intolerance_____ Depression____ Nervousness____ COPD____
Shortness of breath_____ Heart Palpitations_____ Heart murmur____ Chest Pain___ Vertigo____
Fainting____ Peripheral Vascular Disease____ Allergies____ Asthma____ Bronchitis____
Pneumonia____ Reflux/GERD____ GI disorders____ Gallbladder disorders____ Prostate disease____
Bowel irregularity____ Incontinence____ Sexual dysfunction_____ ED____ Venereal disease____
Frequent skin infections____ Hepatitis____ Anemia____ Osteoporosis____ Arthritis____ Gout____
Chronic rashes___

**Specialist you see:** _____

_____

**Patient Record of Disclosure**

We have your permission to disclose medical information/results about yourself or minor patient to the following people. If left blank, we will not be able to advise anyone of your medical status or address question they ask on your behalf.

Patient's Name_____ DOB _____/_____/_____
1. Name:_____ Relationship:_____
2.Name:_____ Relationship: _____
3.Name: _____ Relationship:_____

******Should any of the information above change, it is your responsibility to adivise us of your change and we will have you complete a new disclosure. Otherwise, we will not be held responsible for releasing information to a party you wish to no longer have access to your information.***

_____ Date:_____
Signature