AKLILU & COBIAN INFECTIOUS DISEASES, LLC
PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REFERRING PHYSICIAN: _____ **PHYSICIAN TELEPHONE:** _____

REASON FOR VISIT: _____

ALLERGIES: _____

CURRENT COMPLAINTS:

	YES	NO		YES	NO		YES	NO
Anxiety			Discharge			Incontinence		
Blood in Stool			Dizziness / Fainting			Muscle Weakness		
Bruising / Bleeding			Fatigue			Shortness of Breath		
Diarrhea			Fever			Swollen Glands		
Difficulty Swallowing			Headaches			Weakness		

PAST SURGICAL/PROCEDURE HISTORY:

	Date
Colonoscopy	
Pap Smear	
Mammogram	
Other:	
Other:	
Other:	
Other:	

HOSPITALIZATIONS: (Please list)

	Date

PAST MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO
Allergies/Hay Fever			Edema			Prostate Disease		
Anemia			Epilepsy			Psoriasis		
Arthritis			GI Disorder			Renal Disease		
Asthma			Heart Disease			Scarlet Fever		
Bowel Irregularity			Hepatitis: (Circle) A B C			Sexual Transmitted Diseases		
Cancer Type:			High Cholesterol			Stroke		
Chest Pain/ Angina			Hypertension			Thyroid Disease		
Depression			Liver Disease			Ulcer		
Diabetes			Menstrual Dysfunction			Circulation Problems		

CURRENT MEDICATION LIST:

Medication Name:	Dose:	How Many Times Daily:

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