The CYPRESS Professional Group
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MEDICAL HISTORY

(PLEASE PRINT AND COMPLETE ALL ENTRIES)

NAME _____ **AGE** _____ **DATE OF BIRTH** _____/_____/_____

WHAT IS THE REASON FOR TODAY'S VISIT?

PLEASE LIST YOUR CURRENT MEDICATIONS.

DRUG NAME	DOSAGE	FREQUENCY	DRUG NAME	DOSAGE	FREQUENCY	DRUG NAME	DOSAGE	FREQUENCY
1.			3.			5.		
2.			4.			6.		

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? YES _____ NO _____. IF YES, WHICH DRUG(S)

1. _____ 2. _____ 3. _____ 4. _____

DO YOU OR YOUR BLOOD RELATIVES HAVE ANY HISTORY OF THE FOLLOWING?

	YOU	RELATIVE		YOU	RELATIVE		YOU	RELATIVE
PSYCHIATRIC/EMOTIONAL			**VASCULAR**			**OTHER SYSTEMIC**		
CONDITIONS			HIGH BLOOD PRESSURE			**CONDITIONS**		
DEPRESSION			CHEST PAIN			DIABETES		
ANXIETY			HEART ATTACK			THYROID		
PANIC ATTACKS			HEART MURMUR			KIDNEY		
OBSSESSIONS			IRREGULAR HEART BEAT			BLADDER		
ADD/ADHD &			PACEMAKER			STOMACH		
COMPULSIONS			PHLEBITIS			BOWEL		
LEARNING DISORDERS						HEPATITIS OR		
SLEEP DISORDERS						YELLOW SKIN		
EATING DISORDERS			**LUNGS**			GLAUCOMA		
MOOD SWINGS			BRONCHITIS			ARTHRITIS/JOINT		
DRUG ABUSE			EMPHYSEMA			DEFORMITY		
ALCOHOL ABUSE			ASTHMA			EPILEPSY/SEIZURES		
NICOTINE ABUSE			CHRONIC COUGH			FAINTING		
SCHIZOPHRENIA			MORNING COUGH			CANCERS/TUMORS		

PLEASE ANSWER THEFOLLOWING QUESTIONS:

(WOMEN) ARE YOU PREGNANT? YES_____ NO_____

ANY RECENT BLOOD TESTS? YES_____ NO_____. IF YES, WHEN (DATE) _____ ANY ABNORMAL FINDINGS? _____

ANY RECENT X-RAY PROCEDURES? YES_____ NO_____. IF YES, WHEN (DATE) _____ ANY ABNORMAL FINDINGS? _____

ANY RECENT EEG? YES_____ NO_____. IF YES, WHEN (DATE) _____ ANY ABNORMAL FINDINGS? _____

ANY OTHER RECENT PROCEDURES? YES_____ NO_____. IF YES, PLEASE LIST THE PROCEDURE(S). ANY ABNORMAL FINDINGS? _____

PROCEDURE	DATE	PROCEDURE	DATE	PROCEDURE	DATE
1.		2.		3.	

_____ _____/_____/_____ _____ _____/_____/_____

PATIENT'S SIGNATURE DATE REVIEWED BY DATE