Please circle if you have or have ever been treated for:

Cardiac arrest/ CHF	Hypertension	Diabetes	Asthma	Epilepsy	Athletes foot
Rheumatic fever	Liver disease	Arthritis	Gout	Cancer	Warts
Kidney disease	Stomach/bowel	Stroke	Hepatitis	Lung disease	Measles
Poor circulation	Prolonged bleeding	Ulcers	Fractures	Tuberculosis	Multiple sclerosis
Nerve disorder	Thyroid problem	Phlebitis	Sciatica	Anemia	HIV/AIDS
Foot problem	Chicken Pox	Polio	Fibromyalgia	Osteoporosis	Neuropathy

Please circle if you CURRENTLY have:

Chest pain	Dizziness	Abdomen pain	Bleeding problems	Back pain	Numbness
Claudication	Fever	Constipation	Bruise easily	Hip/knee pain	Tingling
Palpitations	Weight loss	Diarrhea	Difficulty breathing	Joint stiffness	Rash
Eye/vision prob	Nausea	Bloody stools	Shortness of breath	Weakness	Dry, scaly skin

ALLERGIES: Is there a history of skin reaction or other outward reaction or sickness following: circle

Local anesthetics, Codeine, Demerol, Penicillin, X-ray dye, Cortisone, Aspirin, Tylenol, Iodine, Advil, Motrin, Aleve, Adhesive tape, Sulfa ,Other drugs_____

PREVIOUS SURGERY: list with dates

_____

_____

_____

MEDICATIONS: list any you are now taking

_____

_____

_____

FAMILY HISTORY: list relationship to you of family members who have had:

Diabetes_____ Foot Problems_____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

SOCIAL HISTORY:

Do you or did you ever smoke? no yes Packs/day _____ #Years _____

If you quit, when did you do so? _____

Alcoholic beverages? (circle one) None Rarely Moderately Daily Quit

Recreational Drugs? (circle one) None Rarely Moderately Daily Quit

Any sexually transmitted disease? yes no

Is this condition due to an injury? yes no

(If yes please explain on back of paper)

Females: Are you currently pregnant? yes no

I certify that the above information is true, accurate and complete. I hereby give my permission to Dr. Harvey R. Danciger to administer treatment, to use anesthetics or other medications, and to perform such minor procedures as may be deemed necessary in diagnosis and/or treatment. I also give him permission to send a report of findings to my physician(s).

Date_____ Signature _____

Patient (Parent or Guardian if under 18)