Medical History

Irina Lidanova

Name: _____ **Date of Birth:** _____ **Date:** _____

Please help us provide you with a complete evaluation by taking the time to fil out this Questionnaire carefully. All or your answers will be held absolutely confidential. if you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the comments section. Thank you.

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: _____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?_____

_____

How long has it been since your first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? _____

If so, what is it? _____

What kinds of treatment have you tried? _____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES):

[ ] Allergies: _____ [ ] Cancer: _____

[ ] Diabetes: _____ [ ] Hepatitis: _____

[ ] High Blood Pressure: _____ [ ] Heart disease: _____

[ ] Seizures: _____ [ ] Rheumatic Fever: _____

[ ] Surgeries: _____ [ ] Venereal Disease: _____

[ ] Thyroid Disease: _____

[ ] Other significant illness (describe): _____

[ ] Accidents or Significant Trauma (describe): _____

Birth History (prolonged labor, forceps delivery, etc): _____

OTHER RELEVANT MEDICAL HISTORY: _____

_____

_____

_____