Kaveh Akhbari DPM PC
80 West 5th Street
Gilroy, California 95020
Phone: 408-842-0281 Fax: 408-848-4341

MEDICAL HISTORY

PATIENT NAME:_______________________________ **DATE:**____________________

1. Are you **allergic/sensitive** to: (circle appropriate substances) Novocain, Adhesive tape, foods, iodine, penicillin, sulfa drugs, or any other drugs? If so, please state what happens when you are exposed to it:

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2. Please list **all the medications and dosage** that you use regularly:[] or see attached medication list

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3. **Please indicate by checking YES** or **NO if you have had any of the following problems**:

YES	NO	DESCRIPTION	YES	NO	DESCRIPTION	YES	NO	DESCRIPTION
[]	[]	Recent weight loss	[]	[]	Swelling in feet/ankles	[]	[]	Arthritis
[]	[]	Headaches	[]	[]	Numbness in feet/legs	[]	[]	Gout
[]	[]	Trouble with vision	[]	[]	Lower back pain	[]	[]	Thyroid
[]	[]	Trouble with hearing	[]	[]	Stroke	[]	[]	Skin Disease
[]	[]	Anemia	[]	[]	High blood pressure	[]	[]	Peptic Ulcer
[]	[]	Diabetes	[]	[]	Chest Pain	[]	[]	Kidney disease
[]	[]	Circulation problems	[]	[]	Shortness of breath	[]	[]	Depression
[]	[]	Fainting/Epilepsy	[]	[]	Asthma	[]	[]	Anxiety
[]	[]	Cancer__________	[]	[]	Pneumonia	[]	[]	TB
[]	[]	HIV Exposure	[]	[]	Other: ____________________			
[]	[]	Do you Smoke? How much? __________________				[]	[]	Recreational Drugs
[]	[]	Do you Drink? How much? __________________						

Please give details of **ALL** prior Surgeries/Dental Work/Hospitalizations/Injuries:

DESCRIPTION:	**DATE:**

How did you hear from our Office? ______________________________________