ROBERT E. DAVIS, M.D., F.AC.P.

Name (s) and address of physicians with previous medical records:

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Previous hospitalizations: (Place, Date, Reason)

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All previously diagnosed medical and/or surgical illnesses, including childhood:

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Family History: (Parents, uncles, aunts, siblings, children, and grandparents on both sides – be specific)

Diabetes Mellitus ____

Gallbladder (stones, etc.) ____

Heart Disease ____

High Blood Pressure (Hypertension) _______________________________________

Seizure Disorders ____

Colon Disease, (colitis, polyps, etc.)_______________________________________

Cancer____

If yes, name/type: ____

Esophageal Disorders ____

Kidney Disorder ____

Other____

____

Allergies: (Including Medications)

____

____

Blood Transfusions: (Date, amount)

____

Current Medications: (Including non-prescription drugs)

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____

Use of Cigarettes: ______________________ **Coffee:** ______________________________

Amount per day and duration of

Alcohol: ______________________________ **Aspirin:** ____________________________

Type and Amount Or Aspirin Products

Women: Last menstrual period____

Contraceptive Use & Type ____

Any Other Information:

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FOR OFFICE USE ONLY:

WT: ___________**HT:**___________**T:**___________**PR:**___________**BP:**___________