R. CRAIG MCKEE, M.D., LLC

MEDICAL HISTORY: Please fill out completely. This information is important to us in understanding your problem today and in providing safe and effective care for you.

Name:_____ Age:_____ Today's date:_____

Reason for today's visit:_____

Please provide a list of your MEDICATIONS (**including daily aspirin**):_____

_____

_____

_____

List all ALLERGIES TO MEDICATIONS OR MEDICAL PRODUCTS. (For example: tape, latex, contrast dyes, or tetanus vaccine) List "NONE" if you have no known drug allergies: _____

_____

Please list any SURGERIES you have had and the **approximate year**:_____

_____

Please list any CHRONIC MEDICAL ILLNESSES which require you to see a SPECIALIST:_____

_____

_____

Have you been given any steroids within the past three months?_____

Do you smoke?_____ Use a Nicotine Patch or Gum? _____

Is substance abuse of any kind a problem for you? For your safety, discuss this with the doctor.

Your Height_____ Your Weight_____

Have you had a weight change of 20lbs or more in the last 12 months? Yes ____ No____

If yes, did your weight increase ____ or decrease____?

Please CHECK any of the following conditions that you <u>have</u> or <u>have had</u>:

__Liver disease or hepatitis
__Lung Cancer
__Emphysema/COPD
__Home oxygen use
__Asthma
__Kidney failure
__Organ transplant
__High blood pressure
__Mitral valve prolapse
__Artificial heart valve
__Cardiac arrhythmia
__Pacemaker implant
__Defibrillator implant
__Congestive heart failure
__Heart attack
__Bleeding disorder (hemophilia, etc.)
__Deep vein thrombosis or pulmonary embolism
__Stroke
__Vascular disease
__Diabetes
__Facial palsy
__Extremity weakness
__Loss of sensation in extremities
__Rheumatic fever
__Lyme disease
__Menier disease
__Infection with MRSA
__Arthritis
__Joint replacement
__Facial pain
__Shingles
__Herpes
__Glandular disorder (thyroid, adrenal, pituitary)
__Blindness
__Melanoma
__Cancer other than skin
__Stomach ulcer
__Gastric reflux
__Gout
__Tuberculosis
__Glaucoma
__Hearing loss
__Seizure
__Autoimmune disease
__Depression
__Anxiety
__Unusual sweating

- WOMEN ONLY -

Might you be pregnant?_____ Are you nursing? _____