



# SANTA LUCIA MEDICAL GROUP

1336 Natividad Road, Salinas, California 93906

## PAST MEDICAL HISTORY

Do you have a history of...?

(Check boxes that apply to you)

- |   |   |
|---|---|
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Asthma                       |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Blood Transfusions           |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Gout                         |
| <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Lupus                        |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Irritable Bowel Syndrome     |
| <input type="checkbox"/> Shingles             | <input type="checkbox"/> High Cholesterol             |
| <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Cirrhosis                    |
| <input type="checkbox"/> Pancreatitis         | <input type="checkbox"/> Congestive Heart Failure     |
| <input type="checkbox"/> Cardiac Arrhythmia   | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Other (Please note)          |

Do you...? (Please Circle)

- |                           |     |    |                |                          |
|---------------------------|-----|----|----------------|--------------------------|
| Smoke cigarettes          | Yes | No | Packs per week | <input type="checkbox"/> |
| Drink alcoholic beverages | Yes | No | Occasionally   | <input type="checkbox"/> |
| Drink coffee or tea       | Yes | No | Cups per day   | <input type="checkbox"/> |
| Use recreational drugs    | Yes | No | Occasionally   | <input type="checkbox"/> |

Do you have a family history of...?

- |                     |     |    |
|---------------------|-----|----|
| High blood pressure | Yes | No |
| Cancer (what type)  | Yes | No |
| Diabetes            | Yes | No |
| Strokes             | Yes | No |
| Heart Attacks       | Yes | No |
| High Cholesterol    | yes | No |