COLONIAL MEDCARE, P.C.
2801 BOULEVARD, SUITE B
COLONIAL HEIGHTS, VIRGINIA 23836
(804) 524-0524

Patient's Name: _____ Date: _____

Check "Yes" or "No" if you have been treated in the past for any of the following conditions. Circle the appropriate symptom for any questions answered with a "Yes".

	YES	NO
1. High Blood Pressure		
2. Diabetes		
3. Heart Disease, Heart Attack, Angina, Heart Murmur, Abnormal Heart Beat		
4. Chest Pain, Shortness of breath, Lung Disease, Chronic Bronchitis, Asthma, Emphysema		
5. Seizures, Stroke, Severe Headache, Frequent Dizziness		
6. Difficulty with Vision, Glaucoma, Contact lenses, wear glasses		
7. Anemia		
8. Heartburn, Indigestion, Ulcers, Nausea		
9. Constipation, Hemorrhoids, Bleeding with bowel movement		
10. Hernia		
11. Liver Disease, Hepatitis, Gallstones		
12. Kidney Disease, Kidney Stones, Blood in Urine		
13. Joint Pain or swelling, Arthritis, Gout, back pain		
14. Depression, Anxiety, Recent loss or gain of 10 pounds or more		
15. Cancer, if "yes" what body part?		
16. Do you smoke? If "Yes", Packs per day _____ Years smoking_____ If you smoked but quit, when did you quit?_____		
17. Do you consume alcoholic beverages? If "yes" how often?		
18. List all allergies 19. List all surgical procedures.		