Doug A Vermillion, MD
2741 DeBarr Rd., Suite C-214, Anchorage, AK 99508
Phone: 907-644-6055 Fax: 907-644-4885

Name: _____ Height: _____ Weight: _____ Chart # _____

MEDICAL HISTORY: Have you ever been treated for or had any problems with any of the following?

EYES		
Wear corrective lenses	yes	no
Glaucoma	yes	no
EARS		
Hearing loss	yes	no
Hearing devices	yes	no
Ear disease or problems	yes	no
NOSE		
Sinus problems	yes	no
CARDIOVASUCLAR		
Chest pain	yes	no
Irregular or fast heartbeat	yes	no
Low blood pressure	yes	no
High blood pressure	yes	no
Heart disease or murmur	yes	no
RESPIRATORY		
Chronic or frequent cough	yes	no
Shortness of breath	yes	no
Asthma or wheezing	yes	no
Emphysema	yes	no

ENDOCRINE		
Thyroid disease	yes	no
Bloody urine	yes	no
Diabetes	yes	no
Excessive thirst	yes	no
HEMATOLOGICAL/LYMPHATIC		
Bleeding/bruising	yes	no
Blood clotting	yes	no
Anemia	yes	no
Phlebitis	yes	no
Hepatitis: Type _____		
HIV/AIDS	yes	no
NEUROLOGIC		
Fainting	yes	no
Seizures-epilepsy	yes	no
Stroke	yes	no
Paralysis of limbs	yes	no
SKIN		
Skin infections	yes	no
Skin lesions	yes	no
Recent tattoos	yes	no

GASTROINTESTINAL		
Nausea or vomiting	yes	no
Abdominal pain	yes	no
Heartburn	yes	no
URINARY		
Excessive urination	yes	no
Kidney problems	yes	no
Infections	yes	no
ORTHOPEDIC		
Rheumatism	yes	no
Arthritis	yes	no
Gout	yes	no
Bone/joint infection	yes	no
Bone tumor/cyst	yes	no
Artificial joint	yes	no
OTHER PROBLEMS		
Recent weight change	yes	no
Migraines	yes	no
Mental health history	yes	no
Sleeping disorder	yes	no
Sleep apnea	yes	no

PAST SURGICAL HISTORY: Please list all operations that you have had.
_____ Date: _____
_____ Date: _____
_____ Date: _____

FAMILY HISTORY: Please indicate who in your family has had any history as listed below.
Cancer: _____ Heart disease: _____ Lung problems: _____ Diabetes:_____
Gout: _____ Kidney problems: _____High blood pressure: _____Other: _____

PATIENT SOCIAL HISTORY:
Do you drink alcohol? Choose which option applies to you
If you quit using alcohol , how long since you quit? _____
Do you use any form of tobacco? _____ What type? _____ How much? _____ How often? _____ How long? _____
If you quit using tobacco, how long since you quit? _____ What is your occupation? _____
Do you use any recreational drugs? _____ What type? _____ How much? _____ How often? _____
How long? _____If you quit using recreational drugs, how long since you quit? _____
Do you live alone? _____ What are your living arrangements? _____

MEDICATIONS: Please list all medications you are taking including over the counter meds and vitamins or circle if **NONE**
Oral Contraceptives select one Brand_____ Drug: _____ Used for: _____
Drug: _____Used for: _____ Drug: _____ Used for: _____
Drug: _____Used for: _____ Drug: _____ Used for: _____
Drug: _____Used for: _____ Drug: _____ Used for: _____

ALLERGIES: Please list all food and drug allergies or circle if **NONE**
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Patient/Guardian Signature: _____ Date: _____

Comments: _____

REVIEWED BY: _____ Date: _____