Benjamin F. Asher, M.D.

MEDICAL HISTORY

NAME:______________________________ Date of Birth:__________________

Please use reverse side if you need more room.

CHIEF COMPLAINT:
What are your main complaints? State the nature and duration of the symptoms.

MEDICAL HISTORY:
Please list any medical problems (i.e.; heart disease, diabetes, high blood pressure, etc)

ALLERGY/ENVIRONMENTAL:
Do you have asthma ____ environmental allergies____

MEDICATION/SUPPLEMENTS/HERBAL PREPARATION:
Please list all medicines, both prescribed by a physician and over the counter that you are currently taking. Please list nutritional supplements including vitamins, minerals, herbs, homeopathic remedies, etc.

MEDICATION ALLERGY AND INTOLERANCE:
Please list any medication or supplement you are allergic to or which caused unpleasant side effects.

SURGICAL HISTORY:
Please list all surgeries.

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NAME: ______________________

For Women:
Are you pregnant? Yes____ No____

FAMILY HISTORY:
Please describe any medical conditions and illnesses that run in your family.

____
____
____
____

Do you or does anyone in your family have a bleeding disorder? Yes____ No____

ALTERNATIVE MEDICAL HISTORY:
Please list alternative therapies that you currently use or have used (chiropractic, acupuncture, etc.

____
____
____
____

SOCIAL HISTORY:

Do you smoke cigarettes:	Yes____	No____	How much____
	How long have you been smoking ____		
Do you drink alcohol:	Yes____	No____	How Much____
	How often ______________________________		
	What type of alcohol: ____________________		
Do you use drugs:	Yes____	No____	

MENTAL/EMOTIONAL:
How would you describe you stress level: Low____ Medium____ High____

Please list some of the major stressors in your life?

____
____
____
____

Please explain how you handle stress and what you do to relax:

____
____
____