William T. Long, M.D.
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Los Angeles, CA 90057
(213) 484-7600

MEDICAL HISTORY

Name: _____ **DOB:** _____

Past Medical History – Please list below or check boxes that Apply

1. Have you had any medical condition that required hospitalization, emergency room care or care by a physician?

Medical Conditions:

Seizures	☐ Yes ☐ No	Back Problem	☐ Yes ☐ No
HIV	☐ Yes ☐ No	Psychiatric Conditions	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Peptic Ulcer	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart attack	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Cholesterol High	☐ Yes ☐ No

Other _____

Past Surgical History:

Please List all previous surgical procedures and give year or date:

Procedure	**Date**

Medication List:

Please list current medications and dose.
(Bring prescription bottle a list)

Prescription Medications	**Dose**

Over the counter Medication	**Dose**

Allergies:

List any medication or substance that has cause difficulty breathing swelling of the skin, face or mouth, hives, or itching

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Is there a medical condition or illness that runs in your family?

Family Member	Medical Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ **Date/Time:** _____