KEVIN I. PERMAN, MD, P.C.
HEALTH INFORMATION & HISTORY

NAME OF PATIENT: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Height:** _____ **Weight:** _____

Please circle "Yes" or "No" to indicate if you have or had any of the following:

Anemia	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
Emphysema/ COPD	Yes	No	Hypoglycemia	Yes	No
Bronchitis/ Chronic Cough	Yes	No	Thyroid Condition	Yes	No
Sleep Apnea	Yes	No	Cancer	Yes	No
If yes, do you use CPAP?	Yes	No	Melanoma	Yes	No
Tuberculosis	Yes	No	Lupus	Yes	No
Hepatitis (Type ____)	Yes	No	Lazy Eye	Yes	No
Kidney Disease	Yes	No	Poor Color Vision	Yes	No
High Blood Pressure	Yes	No	Retinal Disease	Yes	No
Low Blood Pressure	Yes	No	Blindness	Yes	No
Heart Attack	Yes	No	Glaucoma	Yes	No
Heart Failure	Yes	No	Epilepsy/Seizures	Yes	No
Irregular Heartbeat	Yes	No	Headaches/Migraines	Yes	No
Heart Murmur	Yes	No	AIDS/HIV	Yes	No
Pacemaker	Yes	No	STIs	Yes	No
If yes, does it have an ICD?	Yes	No	Shingles/Herpes	Yes	No
Angina	Yes	No	Are you pregnant?	Yes	No
Stroke	Yes	No	Tobacco Use?	Yes	No
Bleeding Tendencies	Yes	No	Alcohol Use?	Yes	No
Blood Clots/ Embolism	Yes	No	Recreational Drugs?	Yes	No

Current vaccinations (with dates): Flu: _____ **Shingles:** _____ **Pneumonia:** _____

Other MEDICAL CONDITIONS, DISABILITIES, or RISK of FALLING? *If yes, please list:*

_____

MEDICATIONS: ***Please list any medications you are currently taking, including ASPIRIN, herbs, vitamins, and eye drops.***

_____

_____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

ALLERGIES: _____

PRIOR SURGERIES: _____

_____

SIGNATURE: _____ **DATE:** _____

Rev: April 2020