

**RUDOLPH J. MOREIRA, M.D., INC.**  
**MEDICAL HISTORY FORM**  
**PLEASE PRINT!**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ ARE YOU ALLERGIC TO LATEX? \_\_\_\_\_ IODINE? \_\_\_\_\_

LIST ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_

ARE YOU RECEIVING PAIN MEDICATION FROM ANY OTHER DR.? Y N

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER MEDS IF TAKEN REGULARLY): \_\_\_\_\_  
\_\_\_\_\_

IF YOU HAVE A LIST WITH YOU, WE WILL COPY AND YOU MAY WRITE "SEE LIST" ABOVE

PLEASE LIST ANY PRIOR SURGERIES YOU HAVE HAD AND APPROXIMATE YEAR OF SURGERY:  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU SMOKE OR USE TOBACCO? Y N #PACKS/DAY \_\_\_\_\_

DO YOU DRINK ALCOHOL? Y N #DRINKS/DAY \_\_\_\_\_

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? Y N TYPE: \_\_\_\_\_

DO YOU TAKE ASPIRIN DAILY OR BLOOD THINNERS? Y N NAME: \_\_\_\_\_

HAVE YOU EVER TESTED POSITIVE FOR HIV/TB/HEPATITIS? Y N TYPE: \_\_\_\_\_

DO YOU SUFFER FROM **ANY** OF THE FOLLOWING?

DIABETES Y N INSULIN DEPENDENT? Y N MEDICATION \_\_\_\_\_

HEART DISEASE Y N HIGH BLOOD PRESSURE Y N FEVER Y N

NIGHT SWEATS Y N PERSISTENT COUGH Y N WEIGHT LOSS Y N

LEG PAIN Y N DIZZINESS Y N STOMACH ULCERS Y N

OTHER: \_\_\_\_\_

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)