Angel Williamson a place for hope, health and happiness
IMAGING CENTER

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MEDICAL HISTORY

Name:_____ DOB:_____ Date:_____

Have you traveled outside the USA in the last year? Yes____ No____ Where:_____

FAMILY HISTORY	If Living Age	Health	Age at Death	If Deceased Cause	Has any blood Relative ever had:	Please Circle Answer no or yes Who?
Father					Cancer	no yes
Mother					Tuberculosis	no yes
Brother or Sister 1.					Diabetes	no yes
2.					Heart Trouble	no yes
3.					High Blood Pressure	no yes
4.					Stroke	no yes
5.					Epilepsy	no yes
					Mental Illness	no yes
Husband / Wife					Suicide	no yes
Son or Daughter 1.					Birth Defects	no yes
2.					Thyroid Disease	no yes
3.					Alcoholism	no yes
4.						
5.						
6.						

PERSONAL HISTORY (Please circle all answers, yes or no.)

ILLNESSES: Have you ever had

Measles or German Measles	yes	no	Ulcers (stomach or intestinal)	yes	no	Angina	yes	no
Chicken pox or Mumps	yes	no	Hepatitis or Jaundice	yes	no	Heart Failure	yes	no
Whooping cough	yes	no	Gallbladder Disease	yes	no	Rheumatic fever/murmur	yes	no
Scarlet fever or Scarlatina	yes	no	Hiatus hernia	yes	no	High blood pressure	yes	no
Migraine headaches	yes	no	Diverticulosis	yes	no	High cholesterol	yes	no
Stroke or paralysis	yes	no	Kidney Stones or Kidney Failure	yes	no	Diabetes	yes	no
Blindness (even temporary)	yes	no	Bright's Disease	yes	no	Thyroid disease/goiter	yes	no
Seizures or epilepsy	yes	no	Kidney or Urinary tract infections	yes	no	X-ray Therapy / Radiation	yes	no
Meningitis or polio	yes	no	Venereal Disease	yes	no	Nervous Breakdown	yes	no
Pneumonia or pleurisy	yes	no	Gonorrhea or Syphilis	yes	no	Severe Depression	yes	no
Tuberculosis	yes	no	Arthritis or Rheumatism	yes	no	Frequent sore throats	yes	no
Asthma	yes	no	Bursitis, Sciatica, Lumbago	yes	no	Frequent infections	yes	no
Influenza or flu	yes	no	Neuritis or Neuralgia	yes	no	Any other disease:_____		
Hayfever	yes	no	Anemia	yes	no			
Hives or eczema	yes	no	Unusual bleeding or Bruising	yes	no			
Heart Attack	yes	no	Poisoning (food, chemicals, drugs)	yes	no			

Have You Ever Been immunized For (Circle yes or no)

Diphtheria	yes	no	when:_____	Pneumonia	yes	no	when:____
Tetanus	yes	no	when:_____	Influenza	yes	no	when:_____
Polio	yes	no	when:_____	Measles	yes	no	when:_____
German Measles	yes	no	when:_____	Whooping Cough	yes	no	when:_____

Have you ever had a skin test for TB (tuberculosis)? yes no When:_____

INJURIES: **Have you had any:**

Broken bones	yes	no	Sprains or dislocations	yes	no
Lacerations (extensive)	yes	no	Concussion or head injury	yes	no
Ever been knocked out	yes	no	Whiplash	yes	no

TRANSFUSIONS: have you ever had

Blood or Plasma transfusion yes no

HABITS: Do you

Sleep well? yes no Exercise enough? yes no

Is your diet well balanced? yes no

Use alcoholic beverage? yes no

Everyday? yes no

03.01.07cw
Review 06.15.15cw
Revised 06.15.15cw