MEDICAL HISTORY

Patient Name: _____________________________________________________________

Primary Care Physician: ____________________________________________________
PCP’s office location: ______________________________________________________

Please list allergies to any medications: ______________________________________

Please list all of the medications that you take including tablets, capsules, sprays, creams, drops, and vitamins (prescription and over the counter): ________________________________________________________________

Please check all that apply:

☐ High blood pressure ☐ Arthritis ☐ Cancer
☐ Stroke ☐ Endocrine disease ☐ Liver disease
☐ Diabetes ☐ Lung disease ☐ Bleeding disorder
☐ Heart disease ☐ Asthma ☐ Ulcers
☐ Seizure ☐ Mental illness
☐ Fractures or lacerations of the facial area ☐ Eye problems (including dryness if applicable)

Please list any other current or past medical problems: ______________________________

Please list any surgeries you have had (with approximate date): ________________________

Do you use tobacco? ☐ No ☐ Yes
Do you drink alcoholic beverages? ☐ No ☐ Yes

Aspirin or Ibuprofen? ☐ No ☐ Yes

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