Charles Zugerman M.D

312-337-4020

Name _____ **Date** _____

Have you ever had any of the following? Please circle specific diseases	NO	YES
High Cholesterol or Prolonged Bleeding _____	_____	_____
Cardiac Pacemaker, High Blood Pressure, Heart Disease _____	_____	_____
Stomach or Intestinal ulcers, Liver disease or Hepatitis_____	_____	_____
Thyroid Disease, Diabetes, Adrenal Disease _____	_____	_____
Arthritis, Lupus, Scleroderma _____	_____	_____
Kidney Disease_____	_____	_____
Hay Fever, Asthma, Bronchitis, Lung Disease_____	_____	_____
Cold sores, (herpes Simplex), Shingles(zoster), Chicken Pox___	_____	_____
Skin diseases (please specify) _____	_____	_____
Drug Allergies (specify)_____	_____	_____
Keloids (thick scars from surgery or injury)_____	_____	_____
Moles which have changed_____	_____	_____
Skin Cancer (specify)_____	_____	_____
Internal Cancer (specify)_____	_____	_____
Neurological Disease, Strokes, Seizures_____	_____	_____
Other Problems (specify) _____	_____	_____

List Medical Problems that run in your family_____

List All medications that you take at this time_____

List Previous surgeries_____

Please Sign_____