Joseph S. Grasso, DO

Family Practice of Traditional Osteopathic Medicine

MEDICAL HISTORY

PATIENT NAME _____ D.O.B _____ AGE _____

	Patient	Explain/Dates		Family Members	Explain/Dates
☐	Stroke		☐	Stroke	
☐	High Blood Pressure		☐	High Blood Pressure	
☐	Heart Disease/Attack		☐	Heart Disease/Attack	
☐	Angina/chest Pain		☐	Angina/chest Pain	
☐	Diabetes		☐	Diabetes	
☐	Cancer		☐	Cancer	
☐	Birth Defects		☐	Birth Defects	
☐	Mental Tendencies		☐	Mental Tendencies	
☐	Bleeding Tendencies		☐	Bleeding Tendencies	
☐	Lung Disease		☐	Lung Disease	
☐	Frequent/Severe Headaches		☐	Frequent/Severe Headaches	
☐	Seizures		☐	Seizures	
☐	Fainting Spells		☐	Fainting Spells	
☐	Arthritis		☐	Arthritis	
☐	Breast Disease		☐	Breast Disease	
☐	Breast Fibrocystic		☐	Breast Fibrocystic	
☐	Gallstones		☐	Gallstones	
☐	Liver Disease		☐	Liver Disease	
☐	Hepatitis/Orrhosis		☐	Hepatitis/Orrhosis	
☐	Urinary Tract Infection		☐	Urinary Tract Infection	
☐	Stomach Ulcers		☐	Stomach Ulcers	
☐	Other		☐	Other	
☐	Prolonged Antibiotic Use				
☐	Dental History				
☑	Root Canals				
☑	Metal Fillings				
☑	Dental Implants				

Birth History (Forceps/Vacuum Extraction Delivery): _____

Vaccinations: _____ Yes _____ No Any Reactions: _____

Supplements: _____

_____

Medications: _____

_____

_____

Are any other physicians/healthcare practitioners treating you:

Name: _____ Phone/Address: _____

Name: _____ Phone/Address: _____

Name: _____ Phone/Address: _____

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