



Edwin Su, M.D.

Medical Profile

Current Medications (Please include **prescription drugs** and drugs you buy **over the counter**)

Medications:	Reason for taking:	Dose:	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			

Past Medical History

Please list allergies:

Reaction:

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

Review of Systems:

Are you currently having or have had any problems with:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Productive Sputum | <input type="checkbox"/> HIV | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ears, Nose, Throat |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> IBS | <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other 1. _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Depression | 2. _____ |

Previous Illnesses:

Previous Operations:

- | | |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |
| 6. _____ | 6. _____ |

Do you smoke? Yes No
If yes, number of packs per day?

Number of years?

Do you drink? Yes No
If yes, number of drinks per week?
Number of years?