Quality Care Medicine, LLC
Willy Martezian, ARNP-C

Medical History Form

Name: _____ **Date of Birth:** _____

Address: _____SSN: _____

Allergies: _____ **Phone#**_____

Surgery: _____

Height _____ **Weight** _____

Please circle what apply to you:

Cancer:_____	Diabetes	Hypertension	Stroke
Depression/Anxiety	Insomnia	Anemia	Kidney Disease
Heart Disease	Asthma/COPD	Thyroid Disease	A-fib
Memory Loss	High Cholesterol	Arthritis	Osteoporosis
Hepatitis :_____	Seizures	High Blood Pressure	
GERD			

Additional diagnosis: _____

Mammogram: date _____ place _____

^ if **NOT** interested in having Mammogram **(initial here)** _____

Colonoscopy: date _____place _____

^if **NOT** interested in having a Colonoscopy **(initial here)** _____

Power of Attorney Print Name: _____

POA Signature: _____ **Date:** _____