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NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

HT \_\_\_\_\_ WT \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HISTORY OF PRESENT PROBLEM \_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

ASTHMA _____	LUNG DISEASE/DEFECT _____
CANCER _____	HEART DISEASE/DEFECT _____
DIABETES _____	BLACKOUTS OR FAINTING SPELLS _____
CONVULSIONS _____	BLEEDING/CLOTTING DISORDER _____
RHEUMATIC FEVER _____	HIGH BLOOD PRESSURE _____
ULCERS/GASTRITIS _____	

LIST PRIOR SURGERIES AND HOSPITALIZATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST CURRENT MEDICATIONS AND DOSES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF SO, DESCRIBE.

\_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE A FAMILY HISTORY OF:

ARTHRITIS _____	BLOOD DISORDER _____
HEART DISEASE _____	HIGH BLOOD PRESSURE _____
DIABETES _____	CANCER _____
EPILEPSY _____	OTHER _____

ARE YOU PREGNANT? \_\_\_\_\_ YES \_\_\_\_\_ NO

SMOKING HISTORY: \_\_\_\_\_ NON SMOKER \_\_\_\_\_ FORMER SMOKER/QUIT WHEN \_\_\_\_\_  
\_\_\_\_\_ SMOKER \_\_\_\_\_ HOW LONG \_\_\_\_\_ HOW MUCH

IS THERE ANY OTHER INFORMATION YOU FEEL IT WOULD BE VALUABLE FOR THE DOCTOR TO HAVE FOR YOUR EVALUATION TODAY? IF SO, PLEASE PROVIDE. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_