

Patient Name: _____

Date of Birth: ____/____/____

Patient Email: _____ Cell Phone: _____

Home Address: _____ Zip: _____

Reason For Visit: _____ Duration of Symptoms: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes - Non-Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other |

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Father	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Mother	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke

SOCIAL HISTORY

- Education** Less than 8th grade
 High school
 2 year college 4 year college
 Post graduate

- Marital Status** Married Single
 Divorced Separated Widowed
 Domestic partner

- Exercise Level** None (No exercise)
 Occasional exercise
 Moderate exercise
 High level exercise

- Caffeine** None Occasional
 Moderate Heavy
 # of cups/cans per day? _____

- Alcohol** Do you drink alcohol?
 Yes No
 If so, how often?
 Occasionally < 3 times a week
 > 3 times a week
 How many drinks per week? _____

- Tobacco** Do you use tobacco?
 Yes No

- If not currently, did you ever use tobacco?
 Yes No
 Cigarettes - ____ pks./day
 Chew - ____ /day
 Cigars - ____ /day
 # of years _____
 Or year quit _____

- Drugs** Do you currently use recreational or street drugs? Yes No
 If yes, list: _____
