Last Name	First Name	DOB	Age

Street Address	City	State	Zip Code

Daytime Phone Number	Patient/Parent/Gaurdian Email Address

Pediatric Child Weight	Parent/Gaurdian Name

Pharmacy Name	Pharmacy Address	Pharmacy Phone #

Emergency Contact Name	Phone Number:

Medical History Questionnaire

Do you now or have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	If you answered 'yes' on any of the conditions, please explain and give approximate dates here:
Anxiety	☐	☐	Diabetes	☐	☐	
Substance Abuse	☐	☐	Anemia	☐	☐	
High Blood Pressure	☐	☐	Hypersensitivity to Heat/Cold	☐	☐	
Heart Disease	☐	☐	Kidney/Bladder Problems	☐	☐	
Heart Attack	☐	☐	Seizures/Epilepsy	☐	☐	
Pacemaker	☐	☐	Cancer/Tumor	☐	☐	
Vascular Disease	☐	☐	Recent Weight Loss or Gain	☐	☐	
Stroke	☐	☐	Current Infection(s)	☐	☐	
Asthma	☐	☐	Tuberculosis	☐	☐	
Shortness of Breath	☐	☐	Hepatitis	☐	☐	
Chronic Cough	☐	☐	Thyroid Problems	☐	☐	
Faiting Spells	☐	☐	Head Injury/Concussion	☐	☐	
Arthritis	☐	☐	Other	☐	☐	
Recently travelled outside of US:	☐	☐				

Do you have any allergies: _____No _____Yes; If yes, please list:

Are you taking any medications? _____No _____Yes; If yes, please list:

The Information presented here is correct, to the best of my knowledge:

X		
Patient/Parent Signature	Patient Name (Print)	Date:

1580 Holcomb Bridge Road, Suite 17A, Roswell, GA 30076

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