Patient Medical History

Today's Date: ________________

Patient Information

Patient Name	DOB	Birth Sex	Pronouns
		☐ M ☐ F	

Gender Identity

☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male ☐ Transgender Female

Patient History

INDICATE ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST

- ☐ Head/brain injuries or illness (concussion)
- ☐ Seizures, epilepsy
- ☐ Eye problems (except glasses or contacts)
- ☐ Ear and or hearing problems
- ☐ Heart disease, heart attack, bypass
- ☐ Pacemaker, stents, implantable device, or other
- ☐ heart procedures
- ☐ High blood pressure
- ☐ Chronic (long-term) cough, shortness of breath
- ☐ Lung disease (asthma)
- ☐ Kidney problems, kidney stones, pain with urination.
- ☐ Stomach, liver or digestive problems
- ☐ Sleep disorders, pauses in breathing while asleep
- ☐ Daytime sleepiness or loud snoring
- ☐ Diabetes
- ☐ Anxiety, depression, mental health problems
- ☐ Fainting or passing out
- ☐ Dizziness, headaches, numbness, tingling
- Unexplained weight loss
- ☐ Stroke, mini-stroke(TIA), paralysis, weak
- ☐ Neck or back problems
- ☐ Bone, muscle, joint or nerve pain
- ☐ Cancer
- ☐ Chronic (long term)infection

List any other medical conditions that you have had:

Current Medication List

☐ No current medications

Medication	Dose	Frequency

Allergies	☐ No known allergies
Allergy to:	**Reaction:**

Procedures / Surgeries		☐ No procedures or surgeries	
Surgery / Procedure	Date	Surgery / Procedure	Date

Preferred Pharmacy		
Pharmacy Name	Location	Phone

Preventative Screening ☐ Not applicable
Have you had a colonoscopy?
☐ Yes ☐ No If yes, date:
Have you had a mammogram?
☐ Yes ☐ No If yes, date:

Woman's Health ☐ Not applicable
When was your most recent menstrual cycle?
Date:

Family History				
	High Blood Pressure	**Diabetes**	**Cancer**	**Other**
Mother	☐	☐	☐	
Father	☐	☐	☐	
Brother	☐	☐	☐	
Sister	☐	☐	☐	
Other:				

Other Health Issues

Do you drink alcohol?

☐ Yes ☐ No per week:

Do you smoke cigarettes?

☐ Yes ☐ No If yes, per day, years

Do you use other forms of tobacco?

☐ Yes ☐ No Pipe, Cigar or Snuff

Do you vape or use an e-cigarette?

☐ Yes ☐ No If yes, per day, years

Do you use recreational drugs?

☐ Yes ☐ No If yes, per day, years

Current Medication List

Medication	Dose	Frequency

Allergies

Allergy to:	Reaction: