Name: _____

Date of Birth: _____ Current Weight: _____ lbs. Height: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

CURRENT MEDICATIONS

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

ALLERGIES

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

FAMILY MEDICAL HISTORY

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer							
Diabetes							
Heart Disease							
Mental Illness							
High Blood Pressure							

SOCIAL HISTORY

Do you smoke? _____ How often? _____ Do you drink alcohol? _____ How often? _____

SURGICAL HISTORY

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

PATIENT MEDICAL HISTORY

- ☐ Acid Reflux
- ☐ Alcohol Addiction
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis- Type:
- ☐ Atrial Fibrillation
- ☐ Blood Clot
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ COPD
- ☐ Cancer- Type:_____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Hernia
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pulmonary Disease
- ☐ Rectal Bleeding
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Other:_____