

*Patient Name: _____

*Date of Birth _____

MEDICAL HISTORY:

Do you now have, or have you ever had any of the following (PLEASE CHECK ALL THAT APPLY):

- Anemia
- Anxiety
- Asthma/COPD
- Blood disease/Clots
- Cancer /Type: _____
- Cellulitis
- Congestive heart failure
- Coronary artery disease
- Depression
- Diabetes

- Epilepsy
- Fractures
- Glaucoma
- Gout
- Heart attack
- Heart arrhythmia
- High blood pressure
- High cholesterol
- HIV
- Kidney disease

- Liver problems
- Numbness in feet/legs
- Osteoarthritis/Osteoporosis
- Rheumatoid arthritis
- Sleep apnea
- Stomach ulcer
- Stroke
- Thyroid Disorders
- Other: _____

MEDICATIONS:

Please list all **current** medications including **dosages**.

Medicine	Dosage	Medicine	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If diabetic, current A1C: _____ **Date:** _____

ALLERGIES:

Please list any allergies you have to medicines and your reactions. Include adhesive tapes, latex, foods, etc

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

SURGICAL HISTORY:

Please list any surgeries you have had:

FAMILY HISTORY:

Please list disease or illnesses of your immediate family (parents, siblings).

SOCIAL HISTORY:

Do you currently smoke or vape? Y / N Total years of smoking? _____

Former Smoker? Y / N What year did you quit? _____

Drink Alcohol? Y / N How Often and How Much? _____

Recreational Drugs? Y / N How Often and How Much? _____