MEDICAL HISTORY

Today's Date____/____/____

Patient Name:_____Weight:_____Height:_____/_____ DOB:_____

Local Pharmacy: _____
(Name/Address/Phone)

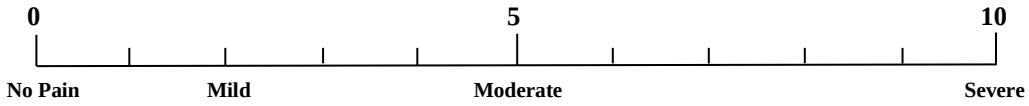
Referred By: _____

Past Medical History:
Have you been diagnosed with any of the following (currently or in the past)?

___ Anesthesia Complications	___ Depression	___ Hepatitis	___ Reflux disease
___ Asthma	___ Diabetes Type 1	___ Hypertension	___ Rheumatoid arthritis
___ Backache	___ Diabetes Type 2	___ Kidney disease	___ Shortness of breath
___ Blood disorder	___ DVT/Blood clot	___ Liver disease	___ Staph infection
___ Cancer	___ Fibromyalgia	___ MRSA	___ Stomach ulcers
___ Cardiac Stent	___ Gout	___ Osteoporosis	___ Stroke
___ Cardiovascular disease	___ Heart attack	___ Pacemaker	___ Thyroid disease

___ Other medical conditions not listed above: _____

Pain Scale (Please Circle):



Allergy History: ☐No Known Allergies ☐No Known Drug Allergies ☐ Latex ☐ Adhesive tape ☐Berries ☐Contrast Dyes ☐Eggs ☐Iodine ☐Nuts ☐Seasonal Allergies ☐ Shellfish ☐ Nickel ☐ Medication Allergies_____

Medication List

☐ I am not currently taking any medications ☐No change since last visit
List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	**Dosage**	**Name of Medication**	**Dosage**
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Past Surgical History (Please include dates):
_____/_____/_____
_____/_____/_____

Social History:
Tobacco Use:
☐ Current every day smoker ☐ Light tobacco smoker ☐ Heavy tobacco smoker
☐ Current some day smoker ☐ Former smoker ☐ Never smoker

Alcohol Use: ☐YES ☐NO ☐ Occasional use ☐ Moderate use ☐ Heavy use

Illicit Drug Use: ☐YES ☐ NO Type:_____ ☐ Quit

Family History:
Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	**Mother**	**Brother**	**Sister**
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
DVT/Blood clot	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Parkinson's disease	_____	_____	_____	_____

Patient Signature: _____ Date: _____