MEDICAL HISTORY

Today's Date____/____/_____

Patient Name:_____Weight:_____Height:_____'_____" DOB:_____

Local Pharmacy:_____
(Name/Address/Phone)

Primary Care Provider:_____
(Name/Address/Phone)

Pain Scale (Please Circle): 0 5 10

No Pain — Mild — Moderate — Severe

Past Medical History:

Have you been diagnosed with any of the following? If **YES**, check which conditions below.

___Acid Reflux (GERD)	___Blood clot	___Heart Attack	___Pacemaker
___AIDS/HIV	___Cancer (type: _____)	___Heart Disease	___Pulmonary Embolism
___Anesthesia Complications	___Cardiac Stent	___Hepatitis	___Rheumatoid Arthritis
___Arthritis	___Depression	___Hypertension	___Seizures/Epilepsy
___Asthma/COPD	___Diabetes (1 or 2)	___Kidney Disease	___Staph Infection/MRSA
___Back Pain	___Fibromyalgia	___Lung Disease	___Stroke
___Bleeding Disorder	___Gout	___Osteoporosis	___Thyroid Problem

Other medical conditions not listed above: _____

Allergies:

Are you allergic to any medications? ☐ **NO** KNOWN DRUG ALLERGIES ☐YES _____

☐**NO** KNOWN ALLERGIES ☐Peanuts ☐Tree nuts ☐Milk ☐Fish ☐Shellfish ☐Soy

☐Wheat ☐Eggs ☐Iodine ☐Latex ☐Nickel ☐Adhesives ☐Contrast Dyes

Medication List:

List any medications and vitamins below. *Use the back of this sheet for more space*

☐ I am **not** currently taking any medications.

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

Past Surgical History:

Please list any past surgeries and include dates. *Use the back of this sheet for more space*

_____/_____/_____/_____

Tobacco Use:
- ☐ Never smoker
- ☐ Former smoker
- ☐ Current some day smoker
- ☐ Current every day smoker

E-Cigarette/ Vape Use:
- ☐ Never user
- ☐ Former user
- ☐ Current user

Alcohol Consumption:
- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

Illicit Drug Use:
- ☐ No
- ☐ Yes

If **yes**, type: _____
_____

Family History:

Place an "**X**" under the family member with the condition, and indicate if and when 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	_____	_____	_____	_____

For patients 65 and over:

Have you fallen in the last three months? ☐YES ☐NO

Do you have a healthcare proxy/living will? ☐YES ☐NO

Patient Signature: _____ Date: _____