Patient History

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Patient Name _____ Date of Birth _____/_____/_____

Your Medical History

Are you allergic to any medications?: ☐ Yes ☐ No

If so, please list here: _____

_____

_____

Please check box if you are allergic to:
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other _____

Have you ever had any of the following?

Acid Reflux	☐ Y ☐ N	Heart Attack	☐ Y ☐ N
Anemia	☐ Y ☐ N	Heart Disease/Failure	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Hepatitis	☐ Y ☐ N
Asthma	☐ Y ☐ N	HIV+/AIDS	☐ Y ☐ N
Back Pain	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N
Blood Clots	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N
• Leg	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
• Lung	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N
• Other	☐ Y ☐ N	Neuropathy	☐ Y ☐ N
Bronchitis/Emphysema	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Cancer	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
If yes, list type and location		Stomach Ulcers	☐ Y ☐ N
_____		Stroke	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Fibromyalgia	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Gout	☐ Y ☐ N		

Other Conditions _____

_____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Name	Dose	How often do you take?

Patient History

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Patient Name _____ Date of Birth ____/____/____

Please list all prior surgeries:

Type of surgery	Date	Type of surgery	Date
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Social History

Patient Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Yes ☐ No ☐ Occasional

Current use of recreational drugs: ☐ Yes ☐ No ☐ Type _____

Use of tobacco: ☐ Never ☐ Quit - How long ago? _____ ☐ Smoke ___ Packs/Day for ____ years

Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

☐ Other _____

Please list the relative who had the disease or condition.

• Diabetes:	Mother	☐ Yes	☐ No	Father	☐ Yes	☐ No	Sibling	☐ Yes	☐ No
• Cancer:	Mother	☐ Yes	☐ No	Father	☐ Yes	☐ No	Sibling	☐ Yes	☐ No
• Heart Disease:	Mother	☐ Yes	☐ No	Father	☐ Yes	☐ No	Sibling	☐ Yes	☐ No
• High Blood Pressure:	Mother	☐ Yes	☐ No	Father	☐ Yes	☐ No	Sibling	☐ Yes	☐ No
• Stroke:	Mother	☐ Yes	☐ No	Father	☐ Yes	☐ No	Sibling	☐ Yes	☐ No
• Thyroid Disease:	Mother	☐ Yes	☐ No	Father	☐ Yes	☐ No	Sibling	☐ Yes	☐ No

• Other: _____

_____