

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

MEDICAL HISTORY: CHECK ALL THAT APPLY

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headache | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Vessel Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Visual Disorders |
| <input type="checkbox"/> Cholesterol/Triglyceride Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Weight Fluctuations |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other: note below _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | <input type="checkbox"/> Stomach/GI Disorder | _____ |
| | <input type="checkbox"/> Injuries | <input type="checkbox"/> Strokes | _____ |

Does or did anyone in your family have any of the following from the above list? If so, please list below:
_____**FAMILY HISTORY: (AGE, OR AGE AT DEATH) LIST SPECIFIC ILLNESS EACH HAD/HAD, OR CAUSE OF DEATH**

Mother: _____

Father: _____

Sibling(s): _____

ALLERGIES ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? IF YES, PLEASE SPECIFY:

CURRENT MEDICATIONS:

Type: _____ MG/Dosage _____ Times per day _____

Type: _____ MG/Dosage _____ Times per day _____

Type: _____ MG/Dosage _____ Times per day _____

Do you or have you used Medical Marijuana (Cannabis) Yes _____ No _____**SOCIAL HISTORY:**

What is your current profession? _____

Have you ever had any of the following? CHECK ALL THAT APPLY

-
- Alcoholism
-
- Drug Addiction/Dependency
-
- Transfusions
-
- Sexually Transmitted Disease (STD)

Do you smoke? Yes No If yes, how much per day? _____ Did you smoke in the past? Yes No

If you quit, when? _____ How much per day? _____ No. of years: _____

Do you exercise? Yes No If yes, what type? _____ How much per week _____Do you consume alcohol? Yes No Type: _____ No. of glasses: _____ day / week**SURGICAL HISTORY: LIST TYPE OF SURGERY DATE**

HEALTH CARE MAINTENANCE:Are you pregnant? Yes No Past pregnancies: _____ Live births: _____

Date of last mammogram: _____ Date of last period: _____ Date of last pap smear: _____

Patient Signature _____

Date _____