

Name: _____ DOB: _____ Date: _____

Past Medical History

<input type="checkbox"/> Anemia	<input type="checkbox"/> NONE	<input type="checkbox"/> GERD	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anxiety	<input type="checkbox"/> CHF	<input type="checkbox"/> Gout	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> STD
<input type="checkbox"/> Arthritis	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Obesity	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peripheral Artery Disease	<input type="checkbox"/> TIA
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> HIV	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Glaucoma			

Give Date of Last: Menstrual period _____, Chemotherapy _____, Radiation _____

Surgical History

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> NONE	<input type="checkbox"/> Hysterectomy, Abdominal	<input type="checkbox"/> Mastectomy, Left	<input type="checkbox"/> Splenectomy
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Coronary Artery Graft	<input type="checkbox"/> Inguinal Hernia Repair	<input type="checkbox"/> Mastectomy, Right	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Bone Surgery	<input type="checkbox"/> Eyes	<input type="checkbox"/> Intestinal/Rectal Surgery	<input type="checkbox"/> Neck Surgery	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Brain Surgery	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Pacemaker, Cardiac	<input type="checkbox"/> Transplant
<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Lung Surgery	<input type="checkbox"/> Sinus surgery	<input type="checkbox"/> Wisdom Teeth
<input type="checkbox"/> Other _____	<input type="checkbox"/> Heart Stent			

Family History

Does your Mother have: Living: _____ Deceased: _____ Cause of Death _____

<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Other _____				

Does your Father have: Living: _____ Deceased: _____ Cause of Death _____

<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Other _____				

Do your Children or Siblings have - Please specify:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Other _____				

Social History

* Tobacco Status: Current Smoker Former Smoker Never Smoked Packs Per Day _____

* Alcohol Drinks: Daily Weekly Monthly Never

* Illegal Drug Use Never used Former User Current User

Current Medications (attach additional page if needed)	Dose	Frequency
Drug Allergies	Reaction	
No known drug allergies mark the box <input type="checkbox"/>		