Name: ______________________________ DOB: ______________________________ Date: ______________________________

Past Medical History

- [ ] NONE

[ ] Anemia	[ ] CHF	[ ] GERD	[ ] Kidney Disease	[ ] Sleep Apnea
[ ] Anxiety	[ ] COPD	[ ] Gout	[ ] Mental Illness	[ ] STD
[ ] Arthritis	[ ] Emphysema	[ ] Heart Attack	[ ] Migraines	[ ] Stroke
[ ] Asthma	[ ] Depression	[ ] Heart Disease	[ ] Obesity	[ ] Thyroid Disease
[ ] Atrial Fibrillation	[ ] Diabetes	[ ] High Blood Pressure	[ ] Peripheral Artery Disease	[ ] TIA
[ ] Blood Clots	[ ] Drug Abuse	[ ] High Cholesterol	[ ] Osteoporosis	
[ ] Cancer	[ ] Glaucoma	[ ] HIV	[ ] Seizures	

[ ] Other____

Give Date of Last: Menstrual period_________, Chemotherapy___________, Radiation____________

Surgical History

- [ ] NONE

[ ] Appendectomy	[ ] Coronary Artery Graft	[ ] Hysterectomy, Abdominal	[ ] Mastectomy, Left	[ ] Splenectomy
[ ] Back Surgery	[ ] Eyes	[ ] Inguinal Hernia Repair	[ ] Mastectomy, Right	[ ] Thyroidectomy
[ ] Bone Surgery	[ ] Gallbladder	[ ] Intestinal/Rectal Surgery	[ ] Neck Surgery	[ ] Tonsillectomy
[ ] Brain Surgery	[ ] Gastric Bypass	[ ] Knee Surgery	[ ] Pacemaker, Cardiac	[ ] Transplant
[ ] Cesarean Section	[ ] Heart Stent	[ ] Lung Surgery	[ ] Sinus surgery	[ ] Wisdom Teeth

[ ] Other____

Family History

Does your Mother have: Living:______Deceased:________Cause of Death______________

[ ] Anemia	[ ] Bleeding Disorders	[ ] Heart Disease	[ ] Kidney disease	[ ] Seizure
[ ] Arthritis	[ ] Cancer	[ ] High Blood Pressure	[ ] Mental Disease	[ ] Stroke
[ ] Asthma	[ ] Diabetes	[ ] High Cholesterol	[ ] Thyroid Disease	[ ] Mental Illness

[ ] Other____

Does your Father have: Living:______Deceased:________Cause of Death______________

[ ] Anemia	[ ] Bleeding Disorders	[ ] Heart Disease	[ ] Kidney disease	[ ] Seizure
[ ] Arthritis	[ ] Cancer	[ ] High Blood Pressure	[ ] Mental Disease	[ ] Stroke
[ ] Asthma	[ ] Diabetes	[ ] High Cholesterol	[ ] Thyroid Disease	[ ] Mental Illness

[ ] Other____

Do your Children or Siblings have - Please specify:

[ ] Anemia	[ ] Bleeding Disorders	[ ] Heart Disease	[ ] Kidney disease	[ ] Seizure
[ ] Arthritis	[ ] Cancer	[ ] High Blood Pressure	[ ] Mental Disease	[ ] Stroke
[ ] Asthma	[ ] Diabetes	[ ] High Cholesterol	[ ] Thyroid Disease	[ ] Mental Illness

[ ] 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 [ ]	

Patient Signature: ____

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