



**PATIENT MEDICAL HISTORY**

**Date:** \_\_\_\_\_

<b>Patient Name (Last – First – Middle Initial)</b>	<b>Age</b>	<b>Weight</b>	<b>Height</b>	
		<b>lbs.</b>	<b>Ft</b>	<b>In</b>

<b>Who is your primary/family doctor?</b>	<b>If you were referred to this clinic by another doctor, please list the doctor's name here</b>
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**Medical History:** Have you ever had any of the following?

<input type="checkbox"/> allergies	<input type="checkbox"/> cancer	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> neuropathy
<input type="checkbox"/> anemia	<input type="checkbox"/> chest pain	<input type="checkbox"/> heart disease	<input type="checkbox"/> pulmonary embolism/blood clot in legs
<input type="checkbox"/> arthritis conditions	<input type="checkbox"/> CHF congestive heart failure	<input type="checkbox"/> hypertension	<input type="checkbox"/> seizure disorders
<input type="checkbox"/> asthma	<input type="checkbox"/> depression	<input type="checkbox"/> infection problems	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> bleeding problems	<input type="checkbox"/> diabetes	<input type="checkbox"/> kidney problems	<input type="checkbox"/> NONE of the problems listed
<input type="checkbox"/> CAD coronary artery disease	<input type="checkbox"/> drug/alcohol abuse	<input type="checkbox"/> migraines/headaches	

**Surgical History:** Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

**Family History:** Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			

**Social History:**

**Marital status:**  Single  Married  Divorced  Widowed  Separated

**Occupation:** \_\_\_\_\_  Retired  Disabled (reason \_\_\_\_\_)

Do you drink alcohol?  **Yes**  **No**,  Daily  Weekly  Infrequently  Recovering Alcoholic

Tobacco use:  Current Smoker ( \_\_\_ packs per day)  Former Smoker  Never Smoked  Chewing Tobacco

**Allergies:**

<input type="checkbox"/> Latex	<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Iodine/Shellfish/Contrast Dye	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Morphine	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> None/No Known Allergies
<input type="checkbox"/> Other _____				

**Medications:** List any medications you are currently taking (please include over the counter medications):  
**PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE**

**Preferred Pharmacy:** \_\_\_\_\_

MEDICATION	DOSAGE	PRESCRIBING DOCTOR