Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Patient's Full Name: _____ Date of Birth: _____

Today's Date: _____ Height: _____Weight: _____ Blood Type: _____

Primary Care Doctor: _____ Referring Doctor: _____

Reason for Visit: _____

Preferred Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Allergies: (List all medications, food and environmental)

_____

_____

Medications: (List all current medications including vitamins & supplements)

Date started	*Medication & Dose*	*Directions*	*Reason for Taking*	*Prescribed by*

Past Medical History: (Please check all that apply)

☐ Attention Deficit Disorder	☐ Dizziness/Vertigo	☐ Headache	☐ Leukemia
☐ Anemia	☐ Depression	☐ Herpes	☐ Migraine Headache
☐ Asthma	☐ Easy Bleeding	☐ HIV Infection	☐ Osteoporosis
☐ Alcohol Disorder	☐ Eczema	☐ Heart Disease	☐ Pneumonia
☐ Bronchitis	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Back Problems	☐ Esophageal Reflux	☐ Hodgkin's Disease	☐ Seizure Disorder
☐ Cancer	☐ Fatigue	☐ Insomnia	☐ Sleep Apnea
☐ Concussion	☐ Gastrointestinal Disorder	☐ Lupus	☐ Stroke Syndrome
☐ Diabetes Mellitus	☐ Glaucoma	☐ Lyme Disease	☐ Thyroid Disorder

Please list any other past medical history:

_____

_____

Past Surgical History: (Please check all that apply and include the date)

Surgery	*Date*	*Surgery*	*Date*	*Surgery*	*Date*
□ Appendectomy		□ Hernia Repair		□ Shoulder Surgery	
□ Back Surgery		□ Hysterectomy		□ Sinus Surgery	
□ Breast Surgery		□ Hip Surgery		□ Tonsillectomy	
□ Cataract Surgery		□ Knee Surgery		□ Thyroid Surgery	
□ C-Section		□ Laparoscopy		□ Vasectomy	
□ Colonoscopy		□ Pacemaker Placement		□ Wisdom Teeth	
□ Cosmetic Surgery		□ Prostate Surgery		□ Other: _____	

Family History: (Please check all that apply)

	Father	*Mother*	*Brother*	*Sister*	*P. Grandfather*	*P. Grandmother*	*M. Grandfather*	*M. Grandmother*
Alcoholism								
Asthma								
Bleeding disorder								
Cancer								
Deceased								
Depression								
Diabetes								
Drug Abuse								
Epilepsy								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Migraines								
Stroke								
Suicide								
Thyroid Problems								

Please list any other family medical history:

_____

_____

Prevention Information:

	Date		*Date*		*Yes*	*No*
Flu Vaccine		Meningitis Vaccine		Do you use seat belts?		
Gardasil Vaccine		PPD/TB Test		Do you have smoke detectors in your home?		
Hepatitis A Vaccine		Pneumonia Vaccine		Do you have a loaded firearm in your home? If yes, how is it stored?		
Hepatitis B Vaccine		Tetanus Vaccine				

Social/Lifestyle History:

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

If married, spouse's name: _____

Children(s) names and age(s): _____

What is your occupation: _____

What are your hobbies: _____

Who lives at home with you: _____

Where were you born and raised: _____

How long have you been in this area: _____

Do you still drive an automobile: _____Do you ride a motorcycle/bicycle: _____

Do you wear a helmet: _____

Do you smoke or use nicotine products: _____ If yes, for how many years: _____

Cigarettes (# Packs/day): _____ Cigars: _____ Pipe: _____ Chew Tobacco: _____

Have you ever used recreational drugs: _____ If yes, when was the last time: _____

What kind did you use: _____

Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products: _____

If yes, which ones and how often: _____

Do you take something to help you sleep: _____ If yes, what and how often: _____

Do you restrict your diet in any way: _____ If yes, how: _____

Do you drink alcohol: □ Never □ Occasionally □ Daily

If yes, how many days per week do you drink alcohol: _____

On a typical day when you drink, how many drinks do you have: _____

Do you drink caffeine: _____ If yes, how much: _____

Ever worked with chemicals, paints, asbestos, or any hazardous material?: _____

If yes, what kind: _____