Medical History

Name: _____ Date: _____

D.O.B: _____ Height: _____ Weight: _____

Allergies

☐ Antibiotics ☐ Sulfa ☐ Foods
☐ Penicillin ☐ Iodine ☐ None
☐ Mycins ☐ Tape ☐_____

Current Medications

_____
_____
_____

Do You Currently Take

☐ Sedatives (Sleep Aids, Tranquilizers)
☐ Anticoagulants (Blood Thinners)
☐ Homeopathic/Herbal Remedies
☐ Aspirin (Excederin, Alka Seltzer)
☐ NSAIDs (Motrin, Advil, Aleve)
☐ Diuretic (Water Pills)
☐ Heart Medication
☐ Steroids

Tobacco

☐ Never ☐ Quit/How Long Ago___
☐ Cigarettes Per Day_____

Alcohol

☐ 1-2 Per Month ☐ None
☐ 1-5 Per Week ☐ >3/day
☐ 1-2 Per Day

- Number of Pregnancies: _____
- Number of Children: _____
- Did You Breast Feed: Yes ___ No___
- Are You Pregnant: Yes___ No___
- Caesarian Section:_____
- Date of Last Mammogram_____
- Normal- Yes____No____

Family History

☐ High Blood Pressure
☐ Prolonged Bleeding
☐ Heart Disease
☐ Diabetes
☐ Breast Cancer
☐ Other Cancer:
_____

Surgeries/Hospitalizations

_____
_____
_____

Do You Have Or Have You Ever Had

☐ Sinus Trouble
☐ Recent Cold/Flu
☐ Pneumonia/Bronchitis
☐ COPD
☐ Shortness of Breath
☐ Asthma
☐ Headaches
☐ Seizures/Epilepsy
☐ Chest Pain
☐ Palpitations
☐ Heart Murmur
☐ Heart Disease
☐ Hypertension
☐ Anemia
☐ Blood Transfusion
☐ Bleed/Bruise Easily
☐ Frequent Urinary Infections
☐ Blood in Urine
☐ Kidney Stones
☐ Ulcers
☐ IBS
☐ Chronic Constipation
☐ Hepatitis
☐ Diabetes
☐ Depression/Anxiety
☐ Skin Cancer
☐ Cancer
☐ Hernia
☐ Breast Lumps
☐ Chemotherapy
☐ Radiation Therapy
☐ HIV Test/Result___

X_____ Date: _____

Patient Signature