Medical History

Name: _____ Date: _____

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

Allergies:

□ Antibiotics □ Sulfa □ Foods
□ Penicillin □ Iodine □ Other:
□ Mycins □ Tape _____

Current Medications:

_____
_____
_____

Do You Currently Take:

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

Family History:

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

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____

Surgeries/Hospitalizations:

_____
_____
_____

Do You Have Or Have You Ever Had:

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

X_____ Date: _____

Patient Signature