PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

Reason for Visit: _____ Current Occupation: _____

How did you hear about our practice? _____

Medication List

Medication Name (include over the counter medication)	Strength/ Dose (mg)	Number of pills per dose	Number of times per day

Past Medical History									
Diabetes		Yes		No	Emphysema/COPD		Yes		No
High Blood Pressure		Yes		No	MRSA		Yes		No
Stroke		Yes		No	Depression/Bipolar		Yes		No
Heart Disease/Heart Attack		Yes		No	Hepatitis B or C		Yes		No
Kidney Stones/Infections		Yes		No	Sleep Apnea		Yes		No
Thyroid Disease		Yes		No	Breast Disease		Yes		No
Seizures		Yes		No	Liver Disease		Yes		No
Bleeding Disorder		Yes		No	High Cholesterol		Yes		No
Mitral Valve Prolapse		Yes		No	Stomach/Bowel problems		Yes		No
Tuberculosis		Yes		No	Glaucoma		Yes		No
Migraines		Yes		No	Osteoporosis		Yes		No
Asthma		Yes		No	Cancer		Yes		No
Anxiety		Yes		No	Details:				
Alcohol/Drug Problems		Yes		No					

Drug/Non-Drug Allergy	Allergic Reaction

Surgical History

Previous Surgeries	Date or Age at the time
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History

				(relationship to you)
Cancer	____ Yes	___ No		
High Blood Pressure	____ Yes	___ No		
Heart Problems	____ Yes	___ No		
Clotting Problem	____ Yes	___ No		
Bleeding Problem	____ Yes	___ No		
Diabetes	____ Yes	___ No		
Breast Cancer	____ Yes	___ No		
Ovarian Cancer	____ Yes	___ No		
Colon Cancer	____ Yes	___ No		
Uterine Cancer	____ Yes	___ No		
Other Cancer: _____	____ Yes	___ No		

Social History

Use of Tobacco:	____Never Smoker ____Former Smoker How long has it been since you last smoked? _____ ____Current Smoker
Use of Drugs:	Other recreational drugs? ____ No ____ Yes If yes, what types? _____
Use of Alcohol:	Do you drink alcohol? ____No ____Yes # of drinks/day _____
Marital Status:	___Single ___Married ___Separated ___Divorced ___Widowed