

MEDICAL HISTORY

PATIENT NAME _____
EMAIL ADDRESS _____
PRIMARY CARE PHYSICIAN _____
ALLERGIES TO MEDICATION(S) _____

Referred by: _____
D.O.B _____
TODAY'S DATE _____

MEDICAL HISTORY (Please check if you have a history of any of the following conditions)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Reflux | <input type="checkbox"/> Speech/Hearing Problems | <input type="checkbox"/> Ulcer Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer (pls. specify) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Deep Vein Thrombosis (DVT) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Bleeding/Clotting Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Jaundice/Hepatitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> HIV/AIDS | OTHER _____ | |

PREVIOUS SURGERIES (Please check if you've had any of the following surgeries)

- | | | | |
|---------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Ear | <input type="checkbox"/> Heart | <input type="checkbox"/> Back/Neck Surgery | <input type="checkbox"/> Tonsil/Adenoid Surgery |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Joints (Hip/Knee) | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> C-Section | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Breast | OTHER _____ | | |

FAMILY HISTORY (Please check if you have a family history of any of the following)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (please specify) | <input type="checkbox"/> Breast Cancer |
| OTHER _____ | | |

MEDICATIONS

	YES	NO	CURRENT MEDICATIONS & DOSAGE
Do you take aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take blood thinning medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take estrogen/progesterone or birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you currently smoke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever smoked	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, how many packs daily _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
How many years _____			_____
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, how much _____			_____
Do you or have you ever used illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, what type _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

VITAL SIGNS

DATE	AGE	BP	PR	RR	Ht	Wt	BMI

PHARMACY

NAME: _____
PHONE NUMBER: _____

ADDRESS: _____