Patient Name: **Date:**

Concerns Today:

Height:

Past Medical History (Check):

☐ Diabetes	☐ Osteoporosis	☐ Blood Clots
☐ Chest Pain/Angina	☐ Asthma/COPD	☐ Peripheral Vascular Disease
☐ High Blood Pressure	☐ Stroke/CVA/TIA	☐ Tuberculosis
☐ Heart Disease	☐ Seizures	☐ Depression
☐ Heart Attack	☐ HIV/AIDS	☐ Anxiety
☐ High Cholesterol	☐ Hepatitis	☐ Congestive Heart Failure
☐ Pacemaker	☐ Stomach Ulcer	☐ Thyroid Disease
☐ Headaches	☐ Liver Disease	☐ Other (list below)
☐ Kidney Stones	☐ Heart Palpitations	_____
☐ Kidney Disease	☐ Arthritis	_____
☐ Cancer	☐ Heart Surgery	_____

Past Surgical and Procedure History (Check):

			Date:
☐ Appendix Removal	☐ Mastectomy	☐ Pap Smear	_____
☐ Gallbladder Removal	☐ Breast Biopsy	☐ Mammogram	_____
☐ Tonsils and Adenoid Removal	☐ Breast Augmentation	☐ Bone Density Scan	_____
☐ Abdominal Uterus and Ovarian Removal	☐ C-Section	☐ Sigmoidoscopy	_____
☐ Vaginal Uterus Removal	☐ Cataracts	☐ Colonoscopy	_____
☐ Tubal Ligation	☐ Vasectomy	☐ Prostate Blood Test	_____

☐ Other:_____

Current Prescribed & Over-The-Counter Medications:

Drug Allergies and Reaction (e.g. Penicillin – Rash): **☐ No Known Drug Allergies**

Social History: Marital Status_____ Occupation_____

Tobacco:	Non-smoker ☐	Ex-Smoker ☐	Current Smoker ☐	Packs per day?_____
Alcohol Consumption:	Never ☐	Occasional ☐	Frequent ☐	

Family History (Please list any know medical problems):

Father:_____ Mother:_____

Siblings:_____

Your Children:_____

Other Treating Physicians or Past Physicians:

* If you want your previous medical records incorporated into our electronic system, please be sure to fill out a release of medical records form for each physician with their phone, address, and fax number if known

Additional Information: Use this space to provide any additional information which may be important to your health care.