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MEDICAL HISTORY

Patient Name _____ DOB _____ Date _____

To help us meet your healthcare needs, please fill out both sides of this form completely. This is a confidential record of your medical history and will not be shared without your authorization.

Reason for Today's Visit: _____ Hand Dominance: R L

PAST MEDICAL HISTORY

No Past Medical History

Please check any that apply.

- | | | |
|----------------------|-------------------------|------------------------------------|
| Arthritis/Type _____ | Fibromyalgia | Kidney Disease/Renal Insufficiency |
| Back Pain | GERD (reflux) | Lung Disease |
| Blood Disorder | Heart Condition/Disease | Osteopenia/Osteoporosis |
| Bone Fractures | Hepatitis/Liver Disease | Pulmonary Embolism/DVT |
| Cancer/Type _____ | High Blood Pressure | Sleep Apnea |
| Depression/Anxiety | High Cholesterol | Thyroid Disease |
| Diabetes/Type _____ | HIV/AIDS | Other _____ |

PAST SURGICAL HISTORY

No Past Surgical History

Please list all operations you have experienced and indicate year they occurred.

- | | | |
|-----------------------------|-------------------------|------------------------|
| Back Surgery _____ | Hand Surgery _____ | Knee Surgery _____ |
| Bowel/Stomach Surgery _____ | Heart Surgery _____ | Neck Surgery _____ |
| Cancer Surgery _____ | Hip Surgery _____ | Shoulder Surgery _____ |
| Fracture/Bones _____ | Joint Replacement _____ | Other _____ |

MEDICATIONS

No Current Medications

Please list all medications you are currently taking, prescribed and over the counter or provide a list.

Current Medication:	Dosage:	How often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

No Allergies

Please list all allergies (Drug, Food & Environment) you have been diagnosed with and reaction.

Allergic To:	Reaction:	Allergic To:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HEALTH HISTORY

Are you Adopted? Yes No

Please indicate if any **Blood Relative** has had any of the following:

Diagnosed With:	Yes	No	Relationship:	Diagnosed With:	Yes	No	Relationship:
Blood Disorder/Type _____			_____	High Blood Pressure			_____
Cancer/Type _____			_____	Kidney Disease			_____
Diabetes			_____	Lung Disease			_____
Heart Disease			_____	Mental Illness			_____

SOCIAL HISTORY

Do you use tobacco? Never Quit/Age _____ Yes, Type and how much per day? _____

Do you drink alcohol? Never Former Yes, How much? _____

Do you use illegal drugs? Never Former Yes

Do you drink caffeine? Never Former Yes

How much do you exercise? Sedentary 1-2 x/month 1-2 x/week 3-4 x/week Daily

Marital Status: Single Married Divorced Widowed Partner

What is your current occupation? _____

What is your education level? Less than high school High school degree Some college
Associate degree Bachelor's degree Master's degree
Doctorate Degree or higher

How comfortable are you filling out medical forms by yourself? Extremely Quite a bit Somewhat A little bit Not at all

Do you have any implantable devices such as Heart Stents or Neuro/Bio Stimulators? No Yes: _____

Patient Name: _____ DOB: _____

Language assistance available

Español | العربية | 繁體中文 | Assyrian | Tiếng Việt | Shqip | 한국어 | | Polski | Deutsch | Italiano | 日本語 |
Русский | Srpsko-hrvatski | Tagalog