PATIENT MEDICAL HISTORY

ALLERGIES:

❑ NONE/KNOWN ALLERGIES	❑ LATEX	❑ SHELL FISH
❑ DAIRY PRODUCTS	❑ ASPIRIN	❑ _____
❑ ADHESIVE TAPE	❑ MORPHINE	❑ _____
	❑ SULFA	❑ _____

FAMILY HISTORY: Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
ARTHRITIS		
CANCER		
DIABETES		
HEART PROBLEMS		
HYPERTENSION		
STROKE		
THYROID DISORDER		
SKIN CONDITIONS		

SOCIAL HISTORY:

☐ YES ☐ NO – DO YOU DRINK ALCOHOL? ☐ DAILY ☐ WEEKLY ☐ INFEQUENTLY ☐ RECOVERING ALCOHOLIC

☐ YES ☐ NO – DO YOU SMOKE? ☐ SMOKE (____ PACKS PER DAY) ☐ CHEW

☐ YES ☐ NO – DO YOU DRINK CAFFEINE? ☐ DAILY ☐ WEEKLY ☐ INFREQUENTLY

SURGICAL HISTORY: list any hospitalizations, surgeries, or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

MEDICAL HISTORY: have you ever had any of the following?

❑ None	❑ Chest Pain	❑ Hyperlipidemia	❑ Others not listed:
❑ Allergies	❑ Congestive Heart Failure	❑ Hypertension	❑ _____
❑ Anemia	❑ Depression	❑ Hypothyroidism	❑ _____
❑ Arthritis	❑ Diabetes	❑ Kidney Problems	❑ _____
❑ Asthma	❑ Drug/ Alcohol Abuse	❑ Neuropathy	❑ _____
❑ Arterial Fibrillation	❑ Erectile Disfunction	❑ Seizure Disorder	❑ _____
❑ Bleeding Problems	❑ Fibromyalgia	❑ Shortness of Breath	❑ _____
❑ Coronary Artery Disease	❑ GERD	❑ Sinus Conditions	❑ _____
❑ Cancer	❑ Heart Disease	❑ Stroke	❑ _____
❑ Cardiac arrest		❑ Tremors	
❑ Celiac Disease			

MEDICATION LIST: Please Provide the office with a list of current medications