Medical History Form **Patient Name:** ________________ **DOB**:________________

Personal Medical History: (indicate if you have had any of the following medical problems)

___High Blood Pressure ___Diabetes ___High Cholesterol ___Heart Disease
___ Thyroid Disorder ___Kidney Disease ___Asthma/Lung Disease ___Depression/Anxiety
___ Cancer: *(specify type)*________________________________ Other: *(specify)*__________________________

Surgical History: *(list all prior surgeries with dates)* ☐ **None**

____
____

Medications: *(list prescription, non-prescription, vitamins, home remedies, herbs etc.)* ☐ **None**

Name	Dose (e.g. mg/pill)	Times per day

Drug allergy/reaction? ____ ☐ **No Known Drug Allergies**
Preferred Pharmacy -name, street, city: ____

Family History: *specify immediate family members (parent, sibling, grandparent, aunt, uncle)* with any of the following

High Blood Pressure:_______________________________ Diabetes:_____________________________________
High Cholesterol:__________________________________ Heart Disease:_________________________________
Stroke:____ Bleeding Disorder:_____________________________
Asthma/COPD:_____________________________________ Depression/suicide:____________________________
Alcoholism/Drug Abuse:____________________________ Genetic Disorder:______________________________
Cancer, specify type:_____________________________________ Other (specify): _________________________

Social History

Tobacco Use:
Cigarettes: ☐ Never ☐ Quit date:__________
☐ Current Smoker packs/day:______ Yrs ______
Other tobacco: ☐ E-cig ☐ Pipe ☐ snuff/chew
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use:
Do you drink alcohol? ☐ Yes ☐ No # drinks/week___
Any concerns about your drinking? ☐ Yes ☐ No

Drug Use:
Do you use recreational drugs? ☐ Yes ☐ No
drug________________ amt____________

Sexual Activity
Sexually active: ☐ Yes ☐ No ☐ Not currently
Current sexual partner is/are: ☐ Male ☐ Female
Birth Control method: _______________ ☐ None

Exercise: Do you exercise regularly? ☐ Yes ☐ No
what kind of exercise?:_________________________
how long (mins)__________ How often? __________

Diet: Balanced/healthy? ☐ Yes ☐ No
daily calcium (specify): _________________________

Weight: Are you satisfied with your weight? ☐ Yes ☐No

Caffeine intake: ☐ None ☐ Coffee/tea/soda/energy drinks
cups per day: _________

Occupation: _________________ hrs per week: _______

Women's Health: # pregnancies_______#deliveries____
abortions ______ #miscarriage_____
Age at start of period ____ Age at end of period ___

How did you hear about our office? ____

____ ____________________
Signature Date