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Patient Name:____ Date of Birth: __________________________

Gender: ☐ Male ☐ Female

Drug/Food Allergies: (List specific reaction if known)____

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Current Medications and Supplements: (Prescription and over-the-counter)__________________________________

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Medical History (Check conditions you have had or currently have)

- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol (Hyperlipidemia)
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Heart Disease/Blockages (Coronary artery disease)
- ☐ Stroke (Cerebrovascular accident)
- ☐ Mini Stroke (TIA/Transient Ischemic Attack)
- ☐ Heart Failure/Congestive Heart Failure
- ☐ Cardiomyopathy (Heart muscle disease)
- ☐ Heart Valve Problem/Heart Murmur
- ☐ Irregular Heart Beat (Arrhythmia)
- ☐ Atrial Fibrillation (A-fib)
- ☐ Diabetes Type 2
- ☐ Diabetes Type 1
- ☐ Pre-Diabetes/Borderline Diabetes (Impaired fasting glucose)
- ☐ Low Thyroid (hypothyroidism)
- ☐ Overactive/High thyroid (hyperthyroidism)
- ☐ Thyroid Cancer
- ☐ PCOS (polycystic ovarian syndrome)
- ☐ Anemia
- ☐ Sickle Cell Disease or Trait
- ☐ Bleeding disorder (hemophilia, von Willebrand's)
- ☐ Blood clots (DVT of leg or pulmonary embolism of lung)
- ☐ Chronic Kidney Disease
- ☐ Renal Failure/Dialysis
- ☐ Enlarged Prostate (BPH)
- ☐ Erectile Dysfunction
- ☐ Testicular Cancer
- ☐ Low Testosterone
- ☐ Uterine Fibroids
- ☐ Endometriosis
- ☐ Hot flashes from menopause (low estrogen)
- ☐ Cervical Cancer
- ☐ Poor Circulation in the Legs (peripheral vascular disease)
- ☐ Aortic aneurysm
- ☐ Asthma
- ☐ COPD/chronic bronchitis/emphysema
- ☐ Pulmonary Fibrosis

Medical History Cont. (Check conditions you have had or currently have)

- ☐ Lung Cancer
- ☐ Sleep Apnea
- ☐ Heartburn/Reflux (GERD)
- ☐ Stomach ulcer (peptic ulcer disease)
- ☐ Hernia
- ☐ Mouth/Esophagus/Stomach Cancer
- ☐ Gallstones/Gallbladder dysfunction
- ☐ Pancreatitis
- ☐ Pancreatic Cancer
- ☐ Broken Bones (Specify Where and When below)
- ☐ Joint Problems (Specify Where below)
- ☐ Back Pain
- ☐ Brittle Bones (Osteopenia/Osteoporosis)
- ☐ Osteoarthritis (arthritis from age, trauma, or wear and tear)
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Lupus/SLE
- ☐ Gout
- ☐ Restless Leg Syndrome
- ☐ Frequent Bladder Infections (UTIs)
- ☐ Kidney Stones (Nephrolithiasis)
- ☐ Fatty Liver
- ☐ Hepatitis
- ☐ Liver cirrhosis
- ☐ Liver cancer/Tumor
- ☐ Irritable Bowel Syndrome/IBS
- ☐ Inflammatory bowel disease/IBD (Crohn's or ulcerative colitis)
- ☐ Diverticulosis/diverticulitis
- ☐ Colon or rectal cancer
- ☐ Diabetes during Pregnancy (Gestational Diabetes)
- ☐ Overactive Bladder
- ☐ Bladder/Kidney Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cyst or Cancer
- ☐ Breast Cancer
- ☐ Glaucoma
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Seasonal Allergies (Allergic Rhinitis/Hayfever)
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Acne
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Headache disorder
- ☐ Migraines
- ☐ Seizure disorder
- ☐ Parkinson's disease
- ☐ Dementia (Alzheimer's, etc.)
- ☐ Nerve Related Pain in Hand/Feet (Peripheral Neuropathy)
- ☐ Dizziness/vertigo
- ☐ Skin Cancer
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety/Panic Disorder
- ☐ Schizophrenia
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Sleeping Problems (Insomnia)
- ☐ Eating Disorder (Anorexia Nervosa, Bulimia)
- ☐ Post Traumatic Stress Disorder/PTSD
- ☐ Attention Deficit Disorder (ADD/ADHD)

Use space below to make comments or to list any additional medical history:____

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Past Surgical History (Check all previous surgeries and provide approximate dates)

Surgery	**Date**
☐ Stenting or Balloning of Arteries (Angioplasty)	____________
☐ Appendix Removal (Appendectomy)	____________
☐ Bariatric/Weight loss Surgery (Bypass, sleeve, lap-band)	____________
☐ Bladder Surgery	____________
☐ Breast Surgery	____________
☐ Carpal Tunnel Release	____________
☐ C-section (Cesarean section)	____________
☐ Removal of all/part of Colon (colectomy)	____________
☐ Gallbladder removal (cholecystectomy)	____________
☐ Heart Bypass (Coronary artery bypass graft/CABG)	____________
☐ Heart Valve Repair/Replacement	____________
☐ Eye/Retinal Surgery (Lasik, Cataracts, Lens implant, etc.)	____________
☐ Hemorrhoid Repair (Hemorrhoidectomy)	____________
☐ Hernia Repair	____________
☐ Removal of Uterus and/or ovaries (Hysterectomy total vs. partial)	____________
☐ Ovary or cervix removal without removal of uterus	____________
☐ Tubes Tied (tubal ligation)	____________
☐ Ear tubes (Myringotomy with tubes)	____________
☐ Orthopedic Surgery (fracture repair, joint replacement, etc.) Specify below	____________
☐ Prostate Surgery	____________
☐ Spinal Surgery (laminectomy, fusion, disc procedure, etc.)	____________
☐ Thyroid Removal (thyroidectomy)	____________
☐ Tonsil/Adenoid Removal (tonsilectomy)	____________
☐ Vasectomy	____________

Use this space to elaborate on surgeries you have marked or additional surgeries____

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Tobacco Use

- Do you currently use tobacco products (cigarettes, chewing tobacco/dipping)?

If yes, please provide further information on the tobacco products you currently use.

Product	Age Started	How much per day
Cigarettes	______________________	______________________
Chewing tobacco	______________________	______________________
Other	______________________	______________________

- If you do not currently use any tobacco products, have you used any in the past?

If yes, please provide the following:

Product	Total years used	How much per day	Stop date
Cigarettes	______________	___________	___________
Chewing tobacco	______________	___________	___________
Other	______________	___________	___________

Illicit Drug Use

- Have you ever used any illicit/illegal drugs? ☐Yes ☐ No
- Do you currently use any illicit/illegal drugs? ☐Yes ☐ No
- Have you ever injected illicit/illegal drugs intravenously (IV)? ☐Yes ☐ No
- For previous or current drug users, what type of drugs did/do you use?

☐ Heroin ☐Cocaine ☐Crack ☐Marijuana ☐Meth ☐Other

Alcohol Use

- Do you currently drink alcohol? ☐ Yes ☐ No
- If yes, h ow often and how much in one occasion? ______________________
- If you are a former alcoholic, how long did you excessively drink? ______________________

Employment Status

- Are you currently employed, if so what is your current occupation? ______________________

Marital Status/Children

☐ Married ☐Single ☐ Separated ☐Divorced ☐Widowed

- Do you have children? If so, how many do you have? ______________________

Reproductive History

- Age at the time of first menstral period ______________________
- Number of times you have been pregnant ______________________
  - Of these, how many times did you give birth? ___________
  - How many times did you have a planned or spontaneous abortion (miscarriage)? ___________
  - How many living children do you have? ___________
- When was the first day of your last menstral period? ___________

Family History (Check all that apply)

Condition	Father	Mother	Brother	Sister	Paternal Grandfather (father's father)	Paternal Grandmother (father's mother)	Maternal Grandfather (mother's father)	Maternal Grandmother (mother's mother)
Alcoholism								
Breast Cancer								
Colon Cancer								
Ovarian Cancer								
Prostate Cancer								
Depression								
Diabetes								
Heart Disease								
High Cholesterol								
High Blood pressure								
Osteoprosis								
Blood clots								
Stroke								
Thyroid problem								
Bleeding disorder								
Headaches/ Migraines								
Heart attacks								

Use the space below to make comments or list additional family history

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Health Maintenance
Provide the approximate month and year you last had the following health screening prodedures done.

Routine blood work/physical exam ________________________________

Colonoscopy ________________________________

Bone density (DEXA) ________________________________

Pap smear/Pelvic exam (Female only) ________________________________

Mammogram (Female) ________________________________

Prostate Exam (Male only) ________________________________

Patient Signature: ____ Date: ____________________

If filling out electronically, please print, sign and bring to appointment with you