Name: _____DOB: _____Date:_____

Past Medical History

- ☐ NONE
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer
- ☐ CHF
- ☐ COPD
- ☐ Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Glaucoma
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Obesity
- ☐ Peripheral Artery Disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Other_____

Give Date of Last: Menstrual period_____, Chemotherapy_____, Radiation_____

Surgical History

- ☐ NONE
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bone Surgery
- ☐ Brain Surgery
- ☐ Cesarean Section
- ☐ Coronary Artery Graft
- ☐ Eyes
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Heart Stent
- ☐ Hysterectomy, Abdominal
- ☐ Inguinal Hernia Repair
- ☐ Intestinal/Rectal Surgery
- ☐ Knee Surgery
- ☐ Lung Surgery
- ☐ Mastectomy, Left
- ☐ Mastectomy, Right
- ☐ Neck Surgery
- ☐ Pacemaker, Cardiac
- ☐ Sinus surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Transplant
- ☐ Wisdom Teeth
- ☐ Other_____

Family History

Does your Father have: Living:_____Deceased:_____Cause of Death_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer/TYPE:_____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Mental Disease
- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other_____

Does your Mother have: Living:_____Deceased:_____Cause of Death_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Mental Disease
- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other_____

Do your Children or Siblings have - Please specify:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Mental Disease
- ☐ Thyroid Disease
- ☐ Seizure
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other_____

Social History

- * **Tobacco Status:** ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked Packs Per Day _____
- * **Alcohol Drinks:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Never
- * **Illegal Drug Use** ☐ Never used ☐ Former User ☐ Current User

Current Medications (attach additional page if neede	Dose	Frequency

Drug Allergies	Reaction

Patient Signature:_____

Name: _____DOB: _____Date:_____

No known drug allergies mark the box ☐	

Patient Signature:_____