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 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_____

**Does your Father 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 needed) | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Drug Allergies | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| **No known drug allergies mark the box** ☐ | |

Patient Signature:_____