

Patient Name: _____ **Date:** _____

Concerns Today: _____

Height: _____

Past Medical History (Check):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Chest Pain/Angina	<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke/CVA/TIA	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Anxiety
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Headaches	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Other (list below)
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Heart Palpitations	_____
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Surgery	_____

Past Surgical and Procedure History (Check):

<input type="checkbox"/> Appendix Removal	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Pap Smear	Date: _____
<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Mammogram	_____
<input type="checkbox"/> Tonsils and Adenoid Removal	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Bone Density Scan	_____
<input type="checkbox"/> Abdominal Uterus and Ovarian Removal	<input type="checkbox"/> C-Section	<input type="checkbox"/> Sigmoidoscopy	_____
<input type="checkbox"/> Vaginal Uterus Removal	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Colonoscopy	_____
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Prostate Blood Test	_____
<input type="checkbox"/> Other: _____			

Current Prescribed & Over-The-Counter Medications:

Drug Allergies and Reaction (e.g. Penicillin – Rash): **No Known Drug Allergies**

Social History: Marital Status _____ Occupation _____
Tobacco: Non-smoker Ex-Smoker Current Smoker Packs per day? _____
Alcohol Consumption: Never Occasional Frequent

Family History (Please list any know medical problems):
Father: _____ Mother: _____
Siblings: _____
Your Children: _____

Other Treating Physicians or Past Physicians:

* If you want your previous medical records incorporated into our electronic system, please be sure to fill out a release of medical records form for each physician with their phone, address, and fax number if known

Additional Information: Use this space to provide any additional information which may be important to your health care.
