Patient's Name:_____Age_____Today's Date:_____

Referring Doctor_____

If you have medical records or health history with you let us make a copy.

Please check any condition that you currently have or have experienced in the past:

□ Arthritis	□ Heart conditions	□ Osteoporosis
□ Cancer	□ Hepatitis	□ Reflux/GERD/Hiatal Hernia
Type_____	□ High blood pressure	□ Rheumatic Fever
□ Chicken Pox	□ HIV	□ Stroke
□ Diabetes	□ Kidney problems	□ Thyroid problems
□ Emphysema/COPD/Asthma	□ Measles	□ Tuberculosis

Do you use tobacco? □ No □ Yes Have you in the past? □ No □ Yes # amount per day_____ What type?_____

# of years smoked_____ # of years ago quit_____

If child does anyone in the household smoke? □ No □ Yes

Do you use alcohol? □ No □ Yes # of drinks per week_____

Past Surgical History Year Year

□ None □ Listed below

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Complaint: _____

_____

_____

_____

Current Medications: (including over the counter, vitamins or herbal preparations) □ None

If you have a list, we can make a copy.

Name of Medication	Dose	Name of Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently on any Aspirin or Blood Thinners? □ No □ Yes If so, which one?_____

Are you allergic to any medications? □ No □ Yes If yes list medication and reaction _____

_____

Other allergies?_____(Seasonal, latex, Betadine, band-aids, etc)

What pharmacy do you prefer? Name_____

FAMILY HISTORY: (Especially Cancer)

Note any chronic illness in family members. If deceased, give the age and cause of death.

Father: _____ Mother:_____

Brother/Sister:_____Spouse:_____

Official use only: Reviewed By _____Date_____

_____Date_____