PATIENT HISTORY

Name_____ Date of Birth_____ Marital Status_____

Race: American Indian/Alaskan Native Asian African American/Black

Native Hawaiian/Pacific Islander Caucasian Other_____

Ethnicity: Hispanic/Latino Other_____

Do you have or have had any of the following conditions:

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer (type)_____
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Gastroesophageal Reflux (GERD)
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Nephropathy/Kidney Disease
- ☐ Obesity/Overweight
- ☐ Osteoporosis
- ☐ Peripheral Neuropathy
- ☐ Retinopathy
- ☐ Seizure/Epilepsy
- ☐ Stroke

Cardiac History

- ☐ CAD
- ☐ CHF
- ☐ Heart Attack
- ☐ Murmur
- ☐ Stents

Additional Medical Conditions

_____
_____
_____
_____

Surgeries and Years

_____
_____
_____
_____

Family History (indicate which relative)

- ☐ High Blood Pressure_____
- ☐ Diabetes_____
- ☐ High Cholesterol_____
- ☐ Depression/Anxiety_____
- ☐ Asthma_____
- ☐ Emphysema/COPD_____
- ☐ Seizure/Epilepsy_____
- ☐ Cancer (type)_____
- ☐ Heart Attack_____
- ☐ Stroke_____

Social History

What is your occupation? _____

Do you smoke? YES NO

If yes, how much? _____

How long? _____

If no, have you ever smoked? YES NO

How long? _____

When did you quit? _____

Do you live with a smoker? YES NO

Do you drink alcohol? YES NO

How many drinks per day? ____

How many drinks per week? ____

Do you drink caffeine? YES NO

How much per day? _____

What do you do for exercise?

_____

Do you use any illegal drugs? YES NO

Latex Allergy? YES NO

Medication Allergies

_____
_____
_____

Medications

_____
_____
_____
_____
_____
_____
_____

Pharmacy Name_____
Pharmacy Number_____

OB/GYN- Women Only

Age you started having periods_____
First day of last menstrual cycle_____
Number of pregnancies_____
Number of deliveries_____
Number of miscarriages_____
Birth control method_____
Date of hysterectomy _____Total/Partial

Health Screening History

Have you had any of the following?

	Date of Test	Physician	Location Performed
Colonoscopy	_____	_____	_____
Mammogram	_____	_____	_____
Pap smear	_____	_____	_____
Bone Density	_____	_____	_____
Eye Exam	_____	_____	_____

Patient Signature_____

Date_____

Specialists

Please list the **NAME** of any specialist listed below that you see

Asthma/Pulmonary_____
Cardiology_____
Endocrinology_____
Gastroenterology_____
OB/GYN_____
Ophthalmology_____
Dermatology_____
Other_____

Immunizations	**Date given**
Flu Shot	_____
Pneumonia	_____
Shingles	_____
Tetanus	_____