Medical History

Patient Name: ______________________________

D.O.B. ____________ Height: ______ft. ______ inches Weight: ________ lbs.

Current Medications *(Prescription and dose, supplements, herbs)*:

1. ____________________ 6. ____________________
2. ____________________ 7. ____________________
3. ____________________ 8. ____________________
4. ____________________ 9. ____________________
5. ____________________ 10. ____________________

Other Medical Problems *(Please list)*: ______________________________

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Past Hospitalizations/surgeries/injuries and approximate dates: ______________________________

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Allergies *(Medication or Latex, please list)*: ______________________________

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Social History:

Tobacco Use: ❐ never ❐ quit (when: __________) ❐ smoker (pack(s) per day ______)

Alcohol Use: ❐ never ❐ rarely ❐ moderate ❐ daily

Drug Use: ❐ never ❐ type and frequency ____________________

marijuana ❐ never ❐ type and frequency ____________________

cocaine ❐ never ❐ type and frequency ____________________

other ❐ never ❐ type and frequency ____________________

Patient Name: ______________________________ D.O.B. ______________

Please check if **you** have any of the following:

- ❒ high blood pressure
- ❒ heart disease
- ❒ bleeding problems
- ❒ diabetes
- ❒ cancer
- ❒ osteoporosis
- ❒ stroke
- ❒ respiratory problems/athsma
- ❒ thyroid disease

Review of Systems: Please check all that apply to you

Constitutional
- ❒ good general health
- ❒ recent weight change
- ❒ night sweats, fevers
- ❒ fatigue

Cardiovascular
- ❒ chest pain
- ❒ palpitations
- ❒ heart trouble
- ❒ swelling hands/feet

Musculoskeletal
- ❒ muscle pain or cramps
- ❒ osteoporosis
- ❒ stiffness/swelling joints
- ❒ joint pain
- ❒ trouble walking

Endocrine
- ❒ excessive thirst/urination
- ❒ thyroid disease
- ❒ hormone problem

Genitourinary *(male only)*
- ❒ blood in urine
- ❒ kidney stones
- ❒ sexual problems
- ❒ testicle pain

Respiratory
- ❒ shortness of breath
- ❒ cough
- ❒ wheezing/asthma
- ❒ coughing up blood

Neurological
- ❒ frequent headaches
- ❒ paralysis or tremors
- ❒ convulsions/seizures
- ❒ numbness/tingling

Hematologic/Lymphatic
- ❒ bruise easily
- ❒ slow to heal
- ❒ enlarged glands

Genitourinary *(female only)*
- ❒ blood in urine
- ❒ kidney stones
- ❒ sexual problems
- ❒ menstrual pain

Gastrointestinal
- ❒ nausea/vomiting
- ❒ abdominal pain
- ❒ rectal bleeding
- ❒ bowel problems

Psychiatric
- ❒ insomnia
- ❒ confusion/memory loss
- ❒ depression
- ❒ other ______________

Have you had a Bone Density Test? ❒ Y ❒ N

Do you take calcium? ❒ Y ❒ N

Do you still have a menstrual cycle? ❒ Y ❒ N

Do you take hormone medication? ❒ Y ❒ N

Please explain any checked box: ______________________________

____

Family History:
Please check if any of your relatives have had any of the following problems, and indicate who:

Heart Disease: ❒ who: ______________

Diabetes: ❒ who: ______________

Cancer: ❒ who: ______________

Osteoporosis: ❒ who: ______________

High blood pressure: ❒ who: ______________

Stroke: ❒ who: ______________

Thyroid Disease: ❒ who: ______________

Patient Statement:
To the best of my knowledge, the above information is accurate.

Signed: ______________________________ Date: ______________