Medical History

Patient Name: _____

Height: _____ft. _____ inches Weight: _____ lbs.

Current Medications *(supplements, herbs)*:

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

Please explain any checked box: _____

_____

_____

Other Medical Problems *(Please list)*: _____

_____

_____

Past Hospitalizations/surgeries/injuries and approximate dates: _____

_____

_____

_____

_____

Allergies *(Medication or Latex, Please list)*: _____

_____

_____

Social History:

Tobacco Use: ❒ never ❒ quit (when: _____) ❒ smoker (pack(s) per day _____)
Alcohol Use: ❒ never ❒ rarely ❒ moderate ❒ daily
Drug Use: ❒ never ❒ type and frequency _____