



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 _____

