Patient's Full Name: _____DOB: _____Today's Date: _____
Allergies: (food, medication, other) _____ [ ] none

Patient and Family Medical History

("Family" includes parents, grandparents, siblings, children of the patient)

Heart Attack / Heart Disease	N	Y – Me	Y – My Family Who?
High Blood Pressure	N	Y – Me	Y – My Family Who:
Blood Clot (in Lungs / Legs)	N	Y – Me	Y – My Family Who?
Blood / Bleeding Disorders	N	Y – Me	Y – My Family Who?
Asthma	N	Y – Me	
Other Lung Problems / Disease	N	Y – Me	Y – My Family Who?
Diabetes	N	Y – Me	Y – My Family Who?
Thyroid Problems	N	Y – Me	Y – My Family Who?
Stomach / Digestive / Bowel Problems	N	Y – Me	
Liver Disease	N	Y – Me	
Bladder or Kidney Infections	N	Y – Me	
Kidney Disease	N	Y – Me	
Autoimmune Disease like Lupus	N	Y – Me	Y – My Family Who?
Cancer	N	Y – Me	Y – My Family Who?
Stroke	N	Y – Me	Y – My Family Who?
Seizures	N	Y – Me	Y – My Family Who?
Migraine Headaches	N	Y – Me	Y – My Family Who?
Degenerative Disease like Parkinson's	N	Y – Me	Y – My Family Who?
Mental Illness / Depression	N	Y – Me	Y – My Family Who?
Physical or Emotional Abuse or Neglect	N	Y – Me	Y – My Family Who?
Addiction to Drugs / Alcohol / Nicotine	N	Y – Me	Y – My Family Who?
Major Accidents	N	Y – Me	
Complications from anesthesia	N	Y – Me	Y – My Family Who?
Hospitalization other than with surgery	N	Y – Me	Why/when

Please list any surgeries you've had: _____
_____

Do you ever use/ take:

Alcohol	N	Y -- Amount per day/ week_____
Tobacco	N	Y-- Amount per day/ week_____
Medications not prescribed to you	N	Y-- What? _____
Street Drugs	N	Y—What? _____

Please list all herbs, vitamins, and supplements you are taking: _____
_____
Please list all over-the-counter medicines you are taking (Tylenol, Motrin, aspirin, etc) _____

Please list all prescription medicines you are taking, how much, and how often_____