MEDICAL HISTORY FORM

Name: _____ **Date of Birth**: _____ **Today's Date**: _____

Current Medications: _____ None OR _____ See List Below **Medication Allergies**_____

Name	Dose/Strength	How Many Times Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Medical History: ____ N/A or Check Below **Personal Surgery History**: _____ N/A or Check Below

Cancer ___ Type _____

Heart Disease ___ Specifics _____

Diabetes ___ High Cholesterol ___ High Blood Pressure ___

Thyroid Disease ___ Asthma ___ COPD ___ GERD ___

Depression ___ Anxiety ___ ADD/ADHD ___ Bipolar ___

Other _____

Cancer Surgery ___ Type/Date _____

Heart Surgery ___ Type/Date _____

Appendix ____ Gallbladder ____ Tonsils/Adenoids ___

Orthopedic Surgery ___ Which Joint? _____

Back or Neck Surgery ___ Nose/ENT ___ Breast ___

Other _____

Conditions in Family Members: ___ N/A or List Below

_____

_____

Tobacco/Nicotine: ___ NEVER ___ PREVIOUS (YEAR QUIT _____) ___ CURRENT (HOW MUCH? _____)

Alcohol Use: ___ NEVER ___ < 4 DRINKS/MONTH ___ 1-4 DRINKS/WEEK ___ 1-2 DRINKS/DAY _____ 3+ DRINKS/DAY

Marijuana Use: ___ NEVER ___ <4 TIMES/MONTH ___ 1-4 TIMES/WEEK ___ DAILY Other Drugs: _____

Preferred Pronouns: ___ He/Him ___ She/Her ___They/Them ___ Other – Please List _____

Living Situation: _ __ Married/Long-Term Partner ___ Single # of Children: ___ # of Children Living with You: ___