

Name: _____ Birthdate: ____ / ____ / ____ Date: ____ / ____ / ____

PATIENT HISTORY

WGT: _____ HGT: _____

Have you ever had or do you have...

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Arthritis (Osteo,Rheumatoid) | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |

Drug Allergies: _____

Current Medications (with dosage): _____

Surgeries: _____

FAMILY HISTORY

Has anyone in your family had...

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Arthritis (Osteo,Rheumatoid) | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |

SOCIAL HISTORY

Do you...

Exercise Regularly

How often: _____

Use Alcohol

How Often? _____

Use Tobacco

_____ per day

PLEASE ANSWER BELOW ONLY IF PATIENT IS A CHILD:

In Day Care? yes no

Smokers at home? yes no Smoke outside Smoke inside