NAME: _____ HEIGHT: _____ WEIGHT: _____ DATE: _____

REASON FOR SEEING OUR PHYSICIAN FOR TODAY: _____

SERIOUS MEDICAL PROBLEMS or INJURIES ☐ NONE

1) _____
2) _____
3) _____
4) _____

PRIOR SURGERIES ☐ NONE DATE

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____

PRESCRIBED MEDICATION ☐ NONE - *or please list below*

	DOSE	FREQUENCY	REASON FOR TAKING
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____

ASPIRIN OR IBUPROFEN PRODUCTS ☐ NONE - *or please list below*
(Advil, Aleve, Motrin, Nuprin, etc.)

	DOSE	FREQUENCY	REASON FOR TAKING
1) _____	_____	_____	_____
2) _____	_____	_____	_____

HERBAL SUPPLEMENTS OR VITAMINS ☐ NONE - *or please list below*

	DOSE	FREQUENCY	REASON FOR TAKING
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____

ALLERGIES and REACTIONS: ☐ NONE - *or please list below*

_____

_____

HAVE YOU EVER USED PRODUCTS CONTAINING NICOTINE? ☐ NO ☐ YES

If Yes, please circle: E-Cigarettes / Cigarettes / Smokeless Tobacco / Cigars / Pipe Tobacco

If yes, please list the approximate date started:_____

If you quit, please list the approximate date stopped:_____

If YES – How much per day? ½ pack full pack other:_____

IF YOU ARE BEING SEEN DUE TO AN ACCIDENT or INJURY:

DATE OF ACCIDENT or INJURY:_____ PLACE (Home, Work etc.) OF ACCIDENT or INJURY: _____

ANY PRIOR TREATMENT? ☐ YES ☐ NO IF SO, WHERE?: _____

****

YOUR PERSONAL HEALTH HISTORY:	**NO**	**YES**	**DESCRIBE**
AIDS/HIV POSITIVE	_____	_____	_____
ANESTHESIA PROBLEMS	_____	_____	_____
AUTOIMMUNE DISORDER	_____	_____	_____
BLEEDING PROBLEMS / BRUISE EASILY	_____	_____	_____
CANCER (breast)	_____	_____	Right _____ Left _____ Bilateral _____
CANCER (skin or other)	_____	_____	_____
CHEST PAIN / TIGHTNESS	_____	_____	_____
DIABETES	_____	_____	Are you on Insulin? _____
HEART PROBLEMS / DISEASE	_____	_____	_____
HEPATITIS / LIVER PROBLEMS	_____	_____	_____
HERPES	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
KELOID SCARS (raised, painful)	_____	_____	_____
KIDNEY PROBLEMS	_____	_____	_____
LATEX ALLERGY	_____	_____	_____
LUNG PROBLEMS (asthma)	_____	_____	_____
MALIGNANT HYPERTHERMIA	_____	_____	_____
LEG BLOOD CLOTS / PULMONARY EMBOLISM	_____	_____	_____
CHEMOTHERAPY	_____	_____	currently _____ in the past _____
RADIATION THERAPY	_____	_____	currently _____ in the past _____
SEIZURE DISORDER (epilepsy)	_____	_____	_____
STEROID USE IN PAST YEAR?	_____	_____	For what reason? _____
STROKE	_____	_____	_____
TUBERCULOSIS	_____	_____	_____
RECEIVED PNEUMOCOCCAL (PNEUMONIA) VACCINE?	_____	_____	Date:_____
RECEIVED INFLUENZA (FLU) VACCINE?	_____	_____	Date:_____
ARE YOU CURRENTLY PREGNANT?	_____	_____	# of pregnancies: _____ children living: _____
DATE OF YOUR LAST PERIOD:	_____		
MAMMOGRAM WITHIN LAST YEAR?	_____	_____	Date:_____

****

FAMILY HISTORY ONLY: (parents, siblings, children only)

	NO	YES	
UNKNOWN FAMILY HISTORY– ADOPTED	_____	_____	
ANESTHESIA PROBLEMS	_____	_____	Affected family member: _____
BLEEDING PROBLEMS / BRUISE EASILY	_____	_____	Affected family member: _____
CANCER - BREAST	_____	_____	Affected family member: _____
CANCER - SKIN	_____	_____	Affected family member: _____
MALIGNANT HYPERTHERMIA	_____	_____	Affected family member: _____