Medical History

Past Medical History: Please circle all that apply for **yourself**

HEART & VESSELS	Hemorrhoids
Hypertension, High blood pressure	Hepatitis
Hyperlipidemia, High Cholesterol	Cirrhosis
CHF, Congestive Heart failure	Cancer
CAD, Coronary Artery Disease	**URINARY**
MI, Heart attack	Kidney Disease
A-fib, irregular heartbeat	Enlarged Prostate
LUNGS	**BRAIN & NERVES**
Sleep Apnea	stroke, TIA
Asthma	Alzheimer's or other dementia
COPD	Multiple Sclerosis
Emphysema	Parkinson Disease
Pulmonary Hypertension	Seizures
Shortness of Breath	Chronic Headaches, Migraines
BLOOD DISORDERS	**MUSCLES & SKELETAL**
Anemia	Osteoporosis or Osteoarthritis
Blood clots, Blood disorder	Rheumatoid Arthritis
Environmental Allergies	Gout
Hernia	Psoriasis
GERD, Heartburn, Reflux	Rosacea
ABDOMEN	**MENTAL DISORDERS**
Hernia	Anxiety or Depression
GERD, Heartburn, Reflux	**ENDOCRINE**
Ulcer-Gastric/Stomach	Diabetes
Colitis or IBS	Thyroid Disease

OTHER:____

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Surgical History: Please list any surgeries or procedures you have had in the past

Surgery or procedure	Date	Physician / Surgeon or Location

Current Medication: Please list all your current medications

Medication Name	Strength (mg, mcg, units)	How often

Allergies: Please list all allergies and your specific reaction

Allergen / Medication Name	**Reaction / Severity**

Family History

Relation	**Medical Conditions**
Father	
Mother	
Grandmother	
Grandfather	
Sister	
Brother	
Aunt	
Uncle	
Daughter	
Son	

Social History: Please circle all that applies to you

Smoking/Tobacco: (Never Smoker) (Former smoker) (Current Every Day Smoker) (Current Some Day Smoker) (Heavy Tobacco Smoker) (Light Tobacco Smoker)

Alcohol: (None) (Occasional/Social) (1-2 Drinks/day) (3-4 Drinks/day)

Substance Abuse: (None) (IVDA) (Cocaine) (Heroin) (Amphetamines) (Marijuana)