Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Social Security #: _____ Date of Birth: _____

Drug Allergies: _____

Weight: _____ Height: _____

Current Medications

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History: Check all syptoms or conditions you have or have had in the past

____ Headache
____ Shortness of Breath
____ Heart Palpitations
____ Heart Murmur
____ Chest Pain
____ Diziness/Fainting
____ Peripheral Vascular Disease
____ Allergies/Hay Fever
____ Asthma
____ Bronchitis
____ Pneumonia
____ Ulcer
____ Nervousness

____ Lactose Intolerance
____ Gall Bladder Disease
____ Prostate Disease
____ Bowel Irregularity
____ Incontinence
____ Sexual/Menstration Dysfunction
____ Venereal Disease
____ Frequent Infections
____ Hepatitis
____ Anemia
____ Arthritis
____ Osteoporosis

____ Depression
____ Gout
____ Scarlet Fever
____ Chronic Rashes
____ Rheumatic Fever
____ Tetanus
____ Mumps
____ Measles
____ Rubella
____ Polio
____ Diphteria
____ GI Disorder

Hospitalizations and/or Surgery: Please list name of hospital, surgeries, and dates

_____ _____

_____ _____

_____ _____

_____ _____

Family History: Indicate in the space provided blood relatives who have or had the following.

Heart Disease: _____ Stroke: _____

High Blood Pressure: _____ Cancer: _____

Mental Illness: _____ Diabetes: _____

Epilepsy/Seizures: _____ Arthritis: _____

Kidney Disease: _____ Stroke: _____

Thyroid Disease: _____ Depression: _____

Habits:

Smoke? Yes No Quit When? _____ Coffee/Tea? Yes No

Alcohol? Yes No Quit When? _____ Excersise? Yes No

Drugs? Yes What? _____ No Quit When? _____