Medical Information

NAME____ DATE_____________________________

Past Medical History

Which of the following conditions are you currently being treated for or have been treated for in the past?

☐Heart disease/murmur/angina ☐Lung Disease ☐Lung Problems/Cough ☐Eye Disorder/Glaucoma ☐Diabetes ☐High Cholesterol

☐Seizures ☐Kidney/Bladder problems ☐High Blood Pressure ☐Stroke ☐heart attack ☐Liver problems/Hepatitis ☐Gout ☐ HIV

☐Headaches/Migraines ☐ Arthritis ☐Heartburn(Reflux) ☐Neurological problems ☐Anemia/Blood Problems ☐Tonsillitis

☐Depression/Anxiety ☐Ulcers/Colitis ☐Thyroid Problems

☐Cancer, What Kind?_______________________________

List any surgeries:____

____

Tobacco Use: Smoke ___Never ____No ___Yes

Quit Date_____________ How Many years **did** you smoke_____________ How Many Packs a Day **did** you smoke _____________

Current Smoker: Packs/day:____________________ # of Years____________________

Alcohol Use: Do you drink alcohol? ___ No ___Yes # of drinks/week_______________

Drug Use: Do you use marijuana or recreational drugs? ___ No ___ Yes

Family History (List serious Illnesses)

Mother: ____

Father: ____

Sister: ____

Brother: ____

Grandparents: ____

Allergies (Include type of reaction) ☐ **None**

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Please List all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc.

☐ **Take No Medications**

Medication Dose (e.g. mg/pill) How many times per day?

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____

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____

____

Immunizations: (Provided year you were given either vaccine.)

Tetanus (Td)_____________ Influenza (Flu Shot)_____________

Women Only: Are you Pregnant? Yes_____ No_______

Blood Pressure _______________