PATIENT:		DOB:	TODAY'S DATE:	HEALTH HISTORY: Pg. 1/4
ACTIVE MEDICATION	IS : Please list up to	•		
Medication Name:		U	osage:	Frequency:
_	•		ow. Include any vita	mins or herbal supplements you are
currently taking (inc	luding medical ma	rijuanaj:		
Do you have any ser	ious/life-threaten	ing side-effects to	medications that wo	uld prohibit you from taking them?
Yes No If Yes, please list:				
PHARMACY INFORM		Yes No		
Do you have a prefer Pharmacy Name:			Pharn	nacy Phone:
Pharmacy Address, C				
ALLERGIES: Are you		ine jonowing subs	Reaction	
Anesthetic		usea LlRash L uscle aches ll :	~ <u>~</u>	☐ Vomiting ☐ Nausea & Vomiting Jin ☐ Headaches ☐ Vertigo
		ficulty waking	1 .	· ·
		,	Hallucinations	/Shortness of breath Unknown Other
lodine on skin			Itching Hives	Vomiting Nausea & Vomiting
lodine on skin			Swelling	
			Shortness of breath	Anaphylactic shock
			Inknown U Other	
Latex			☐ Itching ☐ Hives	☐ Vomiting ☐ Nausea & Vomiting
			Swelling L Joint pa	
			Shortness of breath	☐ Anaphylactic shock
	Ha	Ilucinations 🔲 🛚	nknown U Other	
IV Contrast Dye	Na 🔲	usea 🗌 Rash 📗	Itching Hives	☐ Vomiting ☐ Nausea & Vomiting
	∐ Мι	iscle aches 🔲 :	Swelling 📙 Joint pa	i <u>in</u> Headaches L Vertigo
	<u> </u> Dif	ficulty breathing /	Shortness <u>of</u> breath	Anaphylactic shock
		· —	nknown \square Other	
Animals	ПNа	usea Rash F	Itching Hives	Vomiting Nausea & Vomiting
-			Swelling Joint pa	
			Shortness of breath	Anaphylactic shock
		Ilucinations \square U		
			TIKHOWH LIOUIEI	

Appendix removed Back surgery Brain C-Section C-Section Colon Gallbladder removed Gastric bypass Heart stents Have you had any other surgeries? Have you had any other surgeries? Yes No If yes, please specify and include Year for each one: Heart valve replacement Hernia Hysterectomy Doint surgery Mastectomy/Lumpectomy Ovaries removed Prostate Spleen removed Tubal ligation Heart stents No If yes, please specify and include Year for each one:	PATIENT:	DOB:	TC	DAY'S DAT	E:	HI	ALTH HIST	ΓORY: Pg. 2/4
Muscle aches Swelling Joint pain Headaches Vertigo Difficulty breathing /Shortness of breath Anaphylactic shock Hallucinations Unknown Other	Yes	No	R	eaction				
Rheumatologic (arthritis, gout, lupus, osteoporosis, etc.) Neurological (migraines, Alzheimer's, stroke, seizures, etc.) Neurological (migraines, Alzheimer's, stroke, seizures, etc.) Neurological (migraines, Alzheimer's, stroke, seizures, etc.) Rhental health (Bi-polar, Depressive disorder etc.) Thyroid (Goiter, Graves diseases, Hashimoto's, etc.) Lung (COPD, emphysema, asthma, etc.) Diabetes (Insulin and/or Non-Insulin Dependent, etc.) Hematologic (Blood) (clotting, anemia, sickle cell, etc.) Skin (psoriosis, eczema, rosacea, shingles, etc.) Cancer Heart (heart attack, high blood pressure, arrhythmias, etc.) Gastrointestinal (Crohns, GERD, ulcers, colitis, IBS, etc.) Liver (hepatitis, cirrhosis, fatty liver, etc.) Kidney (stones, recurrent infections, etc.) HIV-AIDS Please list any other Pertinent Medical History or hospitalizations: Please include the date for each hospitalization. PAST SURGICAL HISTORY Yes No Year Heart valve replacement Hernia Hysterectomy Ovaries removed Back surgery Brain Costance(s) Cotorace(s) Cotorace(s) Cotorace(s) Gollbladder removed Gastric bypass Heart bypass Heart bypass Heart stents Have you had any other surgeries? Yes No If yes, please specify and include Year for each one: FAMILY HISTORY: Please indicate if your family members have or have had any of the following Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Father Mother Sibling Child None Unkn Heart disease Hernia Child None Unkn Heart disease Hernia Child None Unkn Heart di	Bee sting	Muscle aches Difficulty breat	Swellin	g D Join	t pain C	Heada	ches	
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Mental health (Bi-polar, Depressive disorder etc.) Thyroid (Goiter, Graves diseases, Hashimoto's, etc.) Lung (COPD, emphysema, asthma, etc.) Diabetes (Insulin and/or Non-Insulin Dependent, etc.) Hematologic (Blood) (clotting, anemia, sickle cell, etc.) Skin (psoriasis, eczema, rosacea, shingles, etc.) Cancer Heart (heart attack, high blood pressure, arrhythmias, etc.) Gastrointestinal (Crohns, GERD, ulcers, colitis, IBS, etc.) Liver (hepatitis, cirrhosis, fatty liver, etc.) Kidney (stones, recurrent infections, etc.) HIV-AIDS Please list any other Pertinent Medical History or hospitalizations: Please include the date for each hospitalization. PAST SURGICAL HISTORY Appendix removed Back surgery Brain Heart valve replacement Hernia Hysterectomy Joint surgery Joint surgery Ovaries removed Gallbladder removed Heart bypass Heart stents Heave you had any other surgeries? Yes No If yes, please specify and include Year for each one: FAMILY HISTORY: Please indicate if your family members have or have had any of the following Father Mother Sibling Child None Unkn Heart disease High blood pressure Diabetes (Insulin and/or Non-insulin Dependent)	Rheumatologic (arthritis, g	gout, lupus, osteoporosis,	etc.)					
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FAMILY HISTORY: Please indicate if your family members have or have had any of the following Father Mother Sibling Child None Unkn Heart disease High blood pressure Diabetes (Insulin and/or Non-Insulin Dependent)	Heart stents							
FAMILY HISTORY: Please indicate if your family members have or have had any of the following Father Mother Sibling Child None Unknown Heart disease High blood pressure Diabetes (Insulin and/or Non-Insulin Dependent)	Have you had any other su	urgeries? Yes N	lo					
Father Mother Sibling Child None Unknown	If yes, please specify and i	nclude Year for each one	:					
Father Mother Sibling Child None Unknown	FAMILY HISTORY: Please	indicate if your family m	embers have	or have ha	ad any of	the follo	wina	
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High blood pressure Diabetes (Insulin and/or Non-Insulin Dependent)	Heart disease		rather	iviotiler	Similing	Cilia	None	Officiown
Diabetes (Insulin and/or Non-Insulin Dependent)								
	•	Non-Insulin Dependent)						
	•							

PATIENT:		DOB:			TODAY'S DATE:			HEALTH HISTORY: Pg. 3/4			
FAMILY HISTORY: (cont	tinued)				Father	Mother	Sibling	Child	None	Unknown
Mental health disorders Thyroid Disease (Goiter) Please check which fam	, Grav	es dise	eases, Has	shimoto	-						
SOCIAL HISTORY:	Yes	No	In the past			Туре				How long?	When Quit?
Drink caffeine?			_	Coffee Other		Tea [Colas	☐ Ener	gy drinks	3	
Use tobacco products?				Cigare Other	tte 🔲	Cigar [☐ Chew	☐ Snuf	f		
Drink alcohol?				Hard li	quor 🔲	Beer [☐ Wine	☐ Oth	er		
Use recreational drugs?				Mariju Cocain Other		Heroin[LSD [hetamine iturates ([
REVIEW OF SYSTEMS (F	ROS)										
General:			Yes	No					Yes	No	
Recent weight changes Fatigue					Fev Gei	ver neral we	akness				
Allergies:			Yes	No					Yes	No	
Seasonal allergies Year-round allergies					Foo	od allergi	es				
Blood:			Yes	No					Yes	No	
Blood clotting problem Easy bruising					Blee	eding tei	ndency				
Eyes, Ears, Nose, & Thre	oat:		Yes	No					Yes	No	
Hearing problems Loss of smell Loss of taste Sinus congestion					Blui	se bleeds rred visio ucoma					
Endocrine:			Yes	No					Yes	No	
Excessively hot Excessively cold					Alw	ays thirs	ty				
Gastrointestinal:			Yes	No					Yes	No	
Difficulty swallowing Nausea Heartburn Blood in stool Increasing constipation Black or tarry stools					Von Bloc Cha	dominal paiting ating ating ating af a great a great distance of a great distance are are are are are are are are are ar	opetite				

PATIENT:	D	ОВ:	TODAY'S DATE:	HEALTH HISTORY: Pg. 4/4		
REVIEW OF SYSTEMS (ROS): (Cont	inued)					
Lungs:	Yes	No		Yes	No	
Wheezing Shortness of breath			Cough Spitting up blood			
Heart:	Yes	No		Yes	No	
Swollen lower extremities Leg pain when walking			Chest pain or pressure Palpitations			
Kidney/Bladder:	Yes	No		Yes	No	
Painful urination Blood in urine			Frequent urination Loss of bladder control			
Muscle/Bone & Joints:	Yes	No		Yes	No	
Joint pain Back pain			Joint swelling Muscle pain or weakness			
Nervous System:	Yes	No		Yes	No	
Headaches Tingling sensations			Dizziness Seizures			
Mental Health/Psychiatric:	Yes	No		Yes	No	
Anxiety Depression			Sleep problems Confusion			
Skin:	Yes	No		Yes	No	
Skin rash Changes in skin color			Skin lesions			
Female Questions:	Yes	No		Yes	No	
Sexual difficulties Female problems			Sexually transmitted disease			
Male Questions:	Yes	No		Yes	No	
Testicular pain Lumps in testicles Discharge from penis			Prostate problems Sexual difficulties Sexually transmitted disease			
• • • • • • • • • • • • • • • • • • • •	-	•	not addressed by this practice, it is cian and/or specialty provider that			
Please list any other physician you	are currer	ntly see	ing: (Physician Name and Reason)			
Physician's Full Name:			Reason:			
This form was completed by: (Plea	se check)					
Patient Parent		Care	giver Guardian		Other	