PATIENT: **DOB:** **TODAY'S DATE:** **HEALTH HISTORY: Pg. 1/4**

ACTIVE MEDICATIONS: Please list up to 10 prescribed medications here

Medication Name:	**Dosage:**	**Frequency:**

If taking more than 10 medications, please list them below. Include any vitamins or herbal supplements you are currently taking (including medical marijuana):

Do you have any serious/life-threatening side-effects to medications that would prohibit you from taking them?

Yes **No**

If Yes, please list:

PHARMACY INFORMATION:	**Yes**	**No**
Do you have a preferred pharmacy?		

Pharmacy Name: Pharmacy Phone:

Pharmacy Address, City, State:

ALLERGIES: ***Are you allergic to any of the following substances***

	Yes	**No**	**Reaction**
Anesthetic			☐ Nausea ☐ Rash ☐ Itching ☐ Hives ☐ Vomiting ☐ Nausea & Vomiting ☐ Muscle aches ☐ Swelling ☐ Joint pain ☐ Headaches ☐ Vertigo ☐ Difficulty waking ☐ Difficulty breathing /Shortness of breath ☐ Anaphylactic shock ☐ Hallucinations ☐ Unknown ☐ Other
Iodine on skin			☐ Nausea ☐ Rash ☐ Itching ☐ Hives ☐ Vomiting ☐ Nausea & Vomiting ☐ Muscle aches ☐ Swelling ☐ Joint pain ☐ Headaches ☐ Vertigo ☐ Difficulty breathing /Shortness of breath ☐ Anaphylactic shock ☐ Hallucinations ☐ Unknown ☐ Other
Latex			☐ Nausea ☐ Rash ☐ Itching ☐ Hives ☐ Vomiting ☐ Nausea & Vomiting ☐ Muscle aches ☐ Swelling ☐ Joint pain ☐ Headaches ☐ Vertigo ☐ Difficulty breathing /Shortness of breath ☐ Anaphylactic shock ☐ Hallucinations ☐ Unknown ☐ Other
IV Contrast Dye			☐ Nausea ☐ Rash ☐ Itching ☐ Hives ☐ Vomiting ☐ Nausea & Vomiting ☐ Muscle aches ☐ Swelling ☐ Joint pain ☐ Headaches ☐ Vertigo ☐ Difficulty breathing /Shortness of breath ☐ Anaphylactic shock ☐ Hallucinations ☐ Unknown ☐ Other
Animals			☐ Nausea ☐ Rash ☐ Itching ☐ Hives ☐ Vomiting ☐ Nausea & Vomiting ☐ Muscle aches ☐ Swelling ☐ Joint pain ☐ Headaches ☐ Vertigo ☐ Difficulty breathing /Shortness of breath ☐ Anaphylactic shock ☐ Hallucinations ☐ Unknown ☐ Other

	Yes	No	Reaction
Bee sting			☐ Nausea ☐ Rash ☐ Itching ☐ Hives ☐ Vomiting ☐ Nausea & Vomiting ☐ Muscle aches ☐ Swelling ☐ Joint pain ☐ Headaches Vertigo ☐ Difficulty breathing /Shortness of breath ☐ Anaphylactic shock ☐ Hallucinations ☐ Unknown ☐ Other

PAST MEDICAL HISTORY

Type of Disease/Disorder: Please check Yes or No	Yes	No	
Rheumatologic *(arthritis, gout, lupus, osteoporosis, etc.)*			
Neurological *(migraines, Alzheimer's, stroke, seizures, etc.)*			
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

	Yes	No	Year		Yes	No	Year
Appendix removed				*Heart valve replacement*			
Back surgery				*Hernia*			
Brain				*Hysterectomy*			
C-Section				*Joint surgery*			
Cataract(s)				*Mastectomy/Lumpectomy*			
Colon				*Ovaries removed*			
Gallbladder removed				*Prostate*			
Gastric bypass				*Spleen removed*			
Heart bypass				*Tubal ligation*			
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	Unknown
Heart disease						
High blood pressure						
Diabetes *(Insulin and/or Non-Insulin Dependent)*						
Cancer						

FAMILY HISTORY: ***(continued)***	**Father**	**Mother**	**Sibling**	**Child**	**None**	**Unknown**
Mental health disorders *(Bi-polar, Depressive disorder etc.)*						
Thyroid Disease *(Goiter, Graves diseases, Hashimoto's, etc.)*						
Please check which family members are deceased :						

SOCIAL HISTORY:	**Yes**	**No**	**In the past**	**Type**	**How long?**	**When Quit?**
Drink caffeine?				☐ Coffee ☐ Tea ☐ Colas ☐ Energy drinks ☐ Other		
Use tobacco products?				☐ Cigarette ☐ Cigar ☐ Chew ☐ Snuff ☐ Other		
Drink alcohol?				☐ Hard liquor ☐ Beer ☐ Wine ☐ Other		
Use recreational drugs?				☐ Marijuana ☐ Heroin ☐ Amphetamines (Speed) ☐ Cocaine ☐ LSD ☐ Barbiturates (Downers) ☐ Other		

REVIEW OF SYSTEMS (ROS)

General:	**Yes**	**No**		**Yes**	**No**	
Recent weight changes			*Fever*			
Fatigue			*General weakness*			

Allergies:	**Yes**	**No**		**Yes**	**No**	
Seasonal allergies			*Food allergies*			
Year-round allergies						

Blood:	**Yes**	**No**		**Yes**	**No**	
Blood clotting problem			*Bleeding tendency*			
Easy bruising						

Eyes, Ears, Nose, & Throat:	**Yes**	**No**		**Yes**	**No**	
Hearing problems			*Nose bleeds*			
Loss of smell			*Blurred vision*			
Loss of taste			*Glaucoma*			
Sinus congestion						

Endocrine:	**Yes**	**No**		**Yes**	**No**	
Excessively hot			*Always thirsty*			
Excessively cold						

Gastrointestinal:	**Yes**	**No**		**Yes**	**No**	
Difficulty swallowing			*Abdominal pain*			
Nausea			*Vomiting*			
Heartburn			*Bloating*			
Blood in stool			*Change of appetite*			
Increasing constipation			*Persistent diarrhea*			
Black or tarry stools						

REVIEW OF SYSTEMS (ROS): *(Continued)*

Lungs:	**Yes**	**No**		**Yes**	**No**
Wheezing			*Cough*		
Shortness of breath			*Spitting up blood*		
Heart:	**Yes**	**No**		**Yes**	**No**
Swollen lower extremities			*Chest pain or pressure*		
Leg pain when walking			*Palpitations*		
Kidney/Bladder:	**Yes**	**No**		**Yes**	**No**
Painful urination			*Frequent urination*		
Blood in urine			*Loss of bladder control*		
Muscle/Bone & Joints:	**Yes**	**No**		**Yes**	**No**
Joint pain			*Joint swelling*		
Back pain			*Muscle pain or weakness*		
Nervous System:	**Yes**	**No**		**Yes**	**No**
Headaches			*Dizziness*		
Tingling sensations			*Seizures*		
Mental Health/Psychiatric:	**Yes**	**No**		**Yes**	**No**
Anxiety			*Sleep problems*		
Depression			*Confusion*		
Skin:	**Yes**	**No**		**Yes**	**No**
Skin rash			*Skin lesions*		
Changes in skin color					
Female Questions:	**Yes**	**No**		**Yes**	**No**
Sexual difficulties			*Sexually transmitted disease*		
Female problems					
Male Questions:	**Yes**	**No**		**Yes**	**No**
Testicular pain			*Prostate problems*		
Lumps in testicles			*Sexual difficulties*		
Discharge from penis			*Sexually transmitted disease*		

If you have answered "yes" to any of the symptoms not addressed by this practice, it is strongly recommended that you address them with your primary care physician and/or specialty provider that handles the specific condition/disease.

Please list any other physician you are currently seeing: *(Physician Name and Reason)*

Physician's Full Name: Reason:

This form was completed by: *(Please check)*

☐ Patient ☐ Parent ☐ Caregiver ☐ Guardian ☐ Other