



Patient Health History

In order to treat you safely and effectively, please answer the following questions.
This is for our records only and responses are confidential.

Last Name _____ First Name _____ Middle Initial _____

Sex M F Birthdate ____/____/____ Age _____ Today's Date ____/____/____

Your Primary Care Physician is: (name, address & phone) _____

Your Pharmacy is: Name _____ City _____ Phone (____) _____

What concerns bring you in today? (Chief complaint) _____

Are you allergic to any medication(s) Yes No (If yes, please specify) _____

List all Medications/Herbs/Vitamins/Supplements you are currently taking and dosage (write "None" if none):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Past Medical History / Family History

(Please answer yes or no and indicate family history on each line listed below - do not leave any blank.)

Disease	Yes	No	Family	Disease	Yes	No	Family
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal or Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any of the following? (Please answer yes or no on each line listed below - do not leave any blank.):

	Yes	No		Yes	No
Fevers/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Joint Aches	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leg Swelling (edema)	<input type="checkbox"/>	<input type="checkbox"/>
Stomach (ie: ulcers, acid reflux, pain)	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

List prior SURGERIES (Write "None" if none) _____

If you are Female: Are you Pregnant? ____Yes ____No Actively trying to become pregnant? ____Yes ____No
Breast Feeding? ____Yes ____No

Do you drink Alcohol? ____Yes ____No # drinks/week _____ Do you Smoke? ____Yes ____No (how often?) _____

Marital status ____Single ____Married ____Divorced ____Widowed Occupation _____

Patient Signature _____ Date _____