Medical History Form

Name: _____ Age _____ DOB: _____

PLEASE COMPLETE THE FOLLOWING (STRICTLY CONFIDENTIAL)

What is the primary reason for your visit? _____

How would you rate your general health? Excellent Good Fair Poor

Do you have any present health concerns or symptoms: _____

List ALL Allergies: (food and medication)

_____ _____

_____ _____

List ALL medication and doses (including over the counter medications)

_____ _____

_____ _____

_____ _____

Do you currently smoke? _____ Yes ____No If yes, how much and how long? _____

Frequency of alcoholic beverages (approx # per week) _____

Any other recreational drugs? Yes _____ No _____

Please indicate if you have any of the following medical problems and when:

Heart Disease	Yes	No	When?	Cancer	Yes	No	When?
High Blood Pressue	Yes	No	When?	GYN Problems	Yes	No	When?
High Cholesterol	Yes	No	When?	Prostate Problems	Yes	No	When?
Thyroid Problems	Yes	No	When?	Alcohol Addiction	Yes	No	When?
Diabetes	Yes	No	When?	Drug Addiction	Yes	No	When?
Clotting Disorder	Yes	No	When?	Eating Disorder	Yes	No	When?
Other _____				Other _____			

Prior Surgeries/Hospitalization:

_____When?_____ _____When?_____

_____When?_____ _____When?_____

Family History:

Heart Disease	Yes	No	Who?_____	Stroke	Yes	No	Who?_____
High Blood Pressure	Yes	No	Who?_____	Blood Clots	Yes	No	Who?_____
High Cholesterol	Yes	No	Who?_____	Cancer	Yes	No	Who?_____
Diabetes	Yes	No	Who?_____	Other _____			

Weight History:

Has your weight changed recently? _____Yes _____No Gained ____ Loss _____ # of lbs _____

Exercise History:

Do you exercise regularly? _____Yes _____No How often? _____ How long? _____