PATIENT HISTORY/ALL INFORMATION IS STRICTLY CONFIDENTIAL

Name: ______________________________________ Birth date: ____________________ Age:_______

Referred by: [ ] Physician ____________________ [ ] Magazine [ ] Friend [ ] Other ____________________

Height: __________ Weight: ______________ Religion: ______________________

PAST MEDICAL HISTORY

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death	Check if your blood relations have/had any of the following:	
Father					Arthritis, Gout	
Mother					Asthma, Hay fever	
Brothers					Breast Cancer	
					Diabetes	
					Heart Disease	
Sister					Hypertension	
					Kidney disease	
					Tuberculosis	
					Other	

MEDICATIONS: List medications you are currently taking	**ALLERGIES**: To any medications or substance

Do you currently take any opioids (pain medication)? ___No ___Yes ___Oxycodone ___ Fentanyl ___Hydrocodone ___Dilaudid ___Codeine ___Demerol ___Methadone ____________________Other

PAST MEDICAL CONDITIONS

[ ] AIDS
[ ] Alcoholism
[ ] Anemia
[ ] Asthma
[ ] Anorexia
[ ] Arthritis
[ ] Gallbladder disease
[ ] Bronchitis
[ ] Bulimia
[ ] Cancer
[ ] Chemical dependency

[ ] Chicken Pox
[ ] HIV
[ ] Colitis/Ulcers
[ ] Constipation/Rectal bleeding
[ ] DES
[ ] Diabetes
[ ] Mumps
[ ] Heart disease
[ ] Headaches/migraines
[ ] Hepatitis/Liver disease

[ ] Hirsutism (excessive hair growth)
[ ] Hypertension
[ ] Hyperlipid
[ ] Kidney disease/Stones
[ ] Measles
[ ] Pacemaker
[ ] Painful urination/incontinence
[ ] Phlebitis/blood clots
[ ] Pneumonia
[ ] Psychiatric care
[ ] Rheumatic fever

[ ] Rubella
[ ] Thyroid Disorder
[ ] Scarlet fever
[ ] Stroke
[ ] Syphilis
[ ] Seizure disorder/epilepsy
[ ] ____________________
[ ] ____________________
[ ] ____________________
[ ] ____________________
[ ] ____________________

PLEASE COMPLETE OTHER SIDE

SURGICAL HISTORY

Date	*Surgery*	*Physician*	*Hospital*	*Complications*

HEALTH HABITS: Please check which substance you use and describe how much/often you use them.			**OCCUPATIONAL CONCERNS:** Please check if your employment exposes you to any of the following.		
	Alcohol			Stress	
	Caffeine			Hazardous Substances	
	Drugs			Heavy Lifting	
	Tobacco			Other	
	Vaping				
	OTHER				

Completed by: Patient [ ] Office Nurse [ ] Physician [ ] Other [ ] ________________________

Signature of Patient: ____

Date reviewed by physician with patient: ____

Physician's signature: ____

Annual Review of History:

Date reviewed: ______________________________ Date reviewed: ______________________________

Date reviewed: ______________________________ Date reviewed: ______________________________

Date reviewed: ______________________________ Date reviewed: ______________________________

Date reviewed: ______________________________ Date reviewed: ______________________________

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