Medical History

Patient Name: ______________________________ Date: ____________________

Date of Birth: __________________ Age: ______ Sex: ☐ Male ☐ Female

Height: __________________ Weight ____________________

Medication Allergies and Intolerance **☐ I have no known medication allergies**

Medication Name	**Reaction**

Current Medication Management **☐ I am not currently taking any medications**

Please list every current medication and the condition for which it was prescribed. Don't forget to include creams, patches, birth control pills, IUD's, inhalers and medications taken "as needed".
If you need more room, please use the back of this sheet.

Medication Name	**Dose**	**Condition**

Medical History **Please check or list any medical conditions affecting you.**

☐ ADD/ADHD	☐ Bronchitis	☐ Frequent UTI's	☐ IBS	☐ Seizures
☐ Anxiety	☐ Cholesterol	☐ GERD	☐ Immune Disorder	☐ Sinusitis
☐ Arthritis	☐ Depression	☐ Gout	☐ Kidney Stones	☐ Skin Condition
☐ Asthma	☐ Diabetes	☐ Heart Problems	☐ Migraines	☐ Stroke
☐ Back Pain	☐ Diverticulitis	☐ Hypertension	☐ Seasonal Allergies	☐ Thyroid Dysfunction

☐ Cancer → Type: ______________________________

☐ Other ____

Family History **Please list any major medical conditions affecting your parents or sibilings.**

____________________________ ☐Father ☐Mother ☐Brother ☐Sister

____________________________ ☐Father ☐Mother ☐Brother ☐Sister

____________________________ ☐Father ☐Mother ☐Brother ☐Sister

Surgical History **Please list all past surgeries including cosmetic surgeries.**

☐Tonsils/Adenoids ☐Ear Tubes ☐Appendectomy ☐Gall Bladder ☐Hysterectomy/Ablation

____________________ ____________________

____________________ ____________________

Alcohol & Tobacco Use **☐ I never drink alcohol** **☐ I have never used tobacco**

How many alcoholic drinks do you usually consume each day? ☐ < 1 ☐ 1-2 ☐ 2-3 ☐ > 3

☐ I currently use tobacco. ________ packs per day ☐ chewing tobacco ☐ cigars

☐ I used to use tobacco but not anymore. When did you last use tobacco? ____________________