Patient Name:_____ Date of Birth: _____

MEDICAL HISTORY: (CHECK ALL THAT APPLY) (MUST BE COMPLETELY FILLED OUT)

- ☐ Dizziness/Vertigo
- ☐ Headache
- ☐ Seizures
- ☐ Stroke
- ☐ Seasonal Allergies
- ☐ Thyroid Disease
- ☐ COPD
- ☐ Asthma
- ☐ Back pain
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Heart murmur
- ☐ Heart Palpitations
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ GERD
- ☐ GI Disease_____
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Mental Illness_____
- ☐ Cancer_____
- ☐ Other_____

FEMALES: **Are you Pregnant?** ☐Yes ☐No **Gestational Age:**_____ weeks **Planning to Become Pregnant?** ☐Yes ☐No

SURGICAL HISTORY:

| **Procedure/Operation** | **Year** |
|---|---|
| | |
| | |
| | |
| | |
| | |

FAMILY HISTORY:

Please include medical problems like Heart Attack, High Blood Pressure, Diabetes, Cancer, etc., and any hereditary conditions

| | |
|---|---|
| Father | |
| Mother | |
| Paternal Grandfather | |
| Paternal Grandmother | |
| Maternal Grandfather | |
| Maternal Grandmother | |
| Siblings | |
| Children | |

DRUG ALLERGIES:

Please list medications you are allergic to including the reaction type i.e. rash, itching, swelling, etc. If you do not have any allergies please state NONE.

_____

_____

_____

_____

CURRENT MEDICATIONS: (Including Over the Counter and As Needed medications)

| **Name of Medication** | **Strength** | **Frequency** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Preferred Pharmacy**:_____ City: _____ State: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

(MUST BE COMPLETELY FILLED OUT)

## Tobacco Usage:

| | | | |
|---|---|---|---|
| Have you ever smoked? □Yes □No | Packs per Day? | How long? | If you quit, when? |
| Do you use smokeless tobacco □Yes □No | Cans per Day? | How long? | If you quit, when? |

Are you interested in quitting tobacco products? □Yes □No

## Alcohol Usage:

| | | | |
|---|---|---|---|
| Do you drink Alcohol? □Yes □No | Type? | How Much? | How Often? |

## Drug Usage:

| | | |
|---|---|---|
| Do you use or abuse illegal or prescription drugs? □Yes □No | Type? | How Often? |

## Birth History: (Please answer this portion if the patient is 0-18 years old)

| |
|---|
| **Birth Weight:** _____lbs _____oz **Gestational Age at Birth: _____** weeks |
| **Delivery:** □Vaginal □Cesarean **If Cesarean, Why?** |
| **Was baby healthy at birth?** □Yes □No, **If no please explain:** |
| **Did mother have any illness or problems during pregnancy?** |
| **Tobacco use during pregnancy?** □Yes □No **Alcohol use?** □Yes □No **Drug use?** □Yes □No, **If yes what drugs?** |
| **Did baby go home from the hospital with mother?** □Yes □No **Explain:** |

## Prevention History:

| |
|---|
| **When was your last Flu Vaccine?** |
| **When was your last;** Pneumonia Vaccine **What type and when?** □Prevnar 13 □Pneumovax 23<br>**When was your last;** COVID-19 Vaccine Shingles Vaccine |
| **When was your last Tetanus Vaccine?** |
| **Have you ever had a colonoscopy?** □Yes □No **If so, when was most recent?** **Was it normal?** □Yes □No |
| **Females only:** |
| **Have you ever had a pap smear?** □Yes □No **If so, when was most recent?** **Was it normal?** □Yes □No |
| **Have you ever had a mammogram?** □Yes □No **If so, when was most recent?** **Was it normal?** □Yes □No |