**Medical History Information**

**Patient name**: _____ **Date:** _____

Reason for appointment: _____

Who referred you to our office:
_____?

Who is your Primary Care Physician: _____

**Height:**_____ **Weight:**_____

**PAST MEDICAL HISTORY**

Name of cardiologist: _____

**Please fill in your medical history:**

No Medical issues ☐

**Acid Reflux/Ulcer**_____
**Arthritis**_____
**Asthma**_____
**Bladder/Kidney Problems**_____
**Bleeding Disorders**_____
**Blood Clots**_____
**Cancer**_____
**COPD**_____
**Diabetes**_____
**Endometriosis**_____
**Glaucoma**_____
**Gout**_____
**Heart Disease**_____
**High Blood Pressure**_____
**High Cholesterol**_____
**High Triglycerides**_____
**HIV**_____
**Intestinal Problems**_____
**Liver Disease**_____
**Neurological Problems**_____
**Pneumonia/Tuberculosis**_____
**Psychiatric Problem**_____
**Skin Problem**_____
**Stroke**_____
**Thyroid/Parathyroid Disorder**_____

Other Conditions: _____

**Please list all past surgeries (All surgeries must be listed; if none, just write none):**

_____

_____

_____

Patient Name:

**Allergies:**

**Current Medications:** Please list any medications you are currently taking (include aspirin, vitamins, herbal supplements):

**Pharmacy:** What Pharmacy do you use and what is the location?

**Social History:**

**Alcohol: Do you drink alcohol?_____If yes, how much_____**

**Do you use any illegal drugs:_____**

**Marital Status: (Please circle one)**

Single Married Separated Divorced Widowed Partnered

Occupation: _____

**Patient Smoking History**

Do you smoke tobacco products?_____ If yes, what kind? _____

Do you use any nicotine products: Chew Tobacco, Gum, patches, E-Cigarettes?_____

**Female History:**

| | | |
|---|---|---|
| Do you have regular periods? | Yes | No |
| Are you going through menopause? | Yes | No |
| Are you pregnant or nursing? | Yes | No |
| During pregnancy, did you have any skin pigment changes? | Yes | No |
| Are you using birth control? | Yes | No |

If yes, please detail _____

**Patient Name: _____**

**Family Medical History:**

No Contributing Family History ☐

| | Who in family | | Who in family |
|---|---|---|---|
| Abnormal Clotting | | Heart Disease | |
| Acid Reflux/GERD | | High Blood Pressure | |
| Adopted | | Kidney Disease | |
| Anesthesia Problems | | Liver Disease | |
| Arthritis | | Lung Cancer | |
| Asthma | | Malignant Hyperthermia | |
| Autoimmune Disorders | | Neurological Problems | |
| Brain Tumor | | Ovarian Cancer | |
| Breast Cancer | | Prostate Cancer | |
| Cancer | | Psychiatric Disease | |
| Cleft Lip | | Skin Cancer | |
| Cleft Palate | | Skin Disease | |
| Diabetes | | Stroke | |
| Endocrine Disease | | Substance Abuse | |
| Glaucoma | | Thyroid/Parathyroid Problem | |
| Hearing Loss | | | |

**Patient Name:**_____

**Review of Systems: Do you currently have, or had you had in the past YEAR:**

| | | | |
|---|---|---|---|
| None Abnormal | ☐ | Burning urination? | ☐ |
| Change in weight? | ☐ | Blood in urine/stool? | ☐ |
| Numbness in limbs? | ☐ | Pain in joints? | ☐ |
| Difficulty swallowing? | ☐ | Heat/cold intolerance? | ☐ |
| Loss of appetite? | ☐ | Dry eyes? | ☐ |
| Blurred vision? | ☐ | Skin rash? | ☐ |
| Hair loss? | ☐ | Diarrhea? | ☐ |
| Shortness of breath? | ☐ | Nausea/Vomiting | ☐ |
| Abdominal pain | ☐ | Constipation? | ☐ |

**Verification**

All information provided above is accurate and complete to the best of my knowledge.

Printed Patient Name:_____Date:_____

Patient Signature: _____Date:_____

Parent or Guardian Signature: _____

PROVIDER SIGNATURE:_____Date:_____