Patient Name ______________________________ DOB: ______________________ Sex________

Allergies ______________________________________________________________

Primary Care Provider ___________________________________________________

Medications (Include over the counter medications that you use)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Medical History

Previous Surgeries No Yes If yes, what type/when?: ______________________________________

Previous Hospitalizations No Yes If yes, what type/when?: ______________________________________

Headaches/Migraines No Yes | Environmental/Seasonal Allergies No Yes

Diabetes No Yes | High Cholesterol No Yes

High Blood Pressure No Yes | Cancer No Yes

Seizures No Yes | Anxiety No Yes

Depression No Yes | Asthma/Breathing Problems No Yes

Blood/Immune System Problems No Yes | Heart Problems No Yes

Liver or Kidney disease No Yes | Thyroid Problems No Yes

Are you currently under a physician, specialist or other healthcare provider's care for any problem?

If yes, please include provider and brief explanation ______________________________________________

Are there any other medical/physical conditions we should know about?

______________________________________________________________________________________

Social History

Cigarette Smoking: Never Previous, but quit When? ___________ Current packs per day ___________

Vaping or any other Tobacco products (including chew): Never Previous, but quit When? __________

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