

**PATIENT HISTORY**

**DATE** \_\_\_\_\_

**NAME** \_\_\_\_\_

**BIRTHDATE** \_\_\_\_\_

DRUG ALLERGIES (List below)	IMMUNIZATIONS	DATE	HOSPITALIZATIONS/SURGERIES	
			REASON	DATE
	Tetanus			
	Flu Vaccine			
	Pneumovax			

**FAMILY HISTORY**

	FATHER	MOTHER	FATHERS PARENTS	MOTHERS PARENTS	SIBLINGS	CHILDREN
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						

NEGATIVE FOR ANY SIGNIFICANT FAMILY HISTORY

**PAST MEDICAL HISTORY**

<input type="checkbox"/> Headache	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowel Irregularity	<input type="checkbox"/> Nervousness/Anxiety
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Sexual/Menstrual Dysfunction	<input type="checkbox"/> Depression
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sexually Transmitted Infection	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chronic Rashes
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> GI Disorder	<input type="checkbox"/> Anemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Measles or Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Other

NEGATIVE FOR ANY SIGNIFICANT MEDICAL HISTORY

**NOTES:** \_\_\_\_\_

**DO YOU FEEL SAFE AT HOME, WORK AND SCHOOL:** Yes \_\_\_ No \_\_\_ **Comments:** \_\_\_\_\_

**HABITS:**

<input type="checkbox"/> Smoke:	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Coffee	<input type="checkbox"/> Diet:
Amount?	Type:	Cups Daily:	Salt Intake:
How Long?	Amount:	Other Caffeine?	Fat Intake
Quit? Date:			

Exercise Routine: \_\_\_\_\_

Sleep Pattern: \_\_\_\_\_

Contact with Blood and/or body fluids at work: \_\_\_\_\_