MEDICAL HISTORY FORM

NAME: ____________________________ DATE: ________________

NAME OF PRIMARY CARE PHYSICIAN ____________________________ PHONE # OF PCP: __________

Height: __________ Weight: __________

ARE YOU ALLERGIC TO ANY MEDICATIONS? □ YES □ NO

IF YES, PLEASE LIST ALL MEDICATION AND REACTIONS:

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

PLEASE LIST ANY SURGERIES WITH DATES:

REVIEW OF SYSTEMS

Have you had or do you have an ulcer? □ YES □ NO

Are you pregnant at this time? □ YES □ NO

Do you have any respiratory conditions? □ YES □ NO

Are you diabetic? □ YES □ NO

Do you have any skin ulcers or rashes? □ YES □ NO

Do you have a history of seizures, strokes or headaches? □ YES □ NO

Do you have a history of depression or nervousness? □ YES □ NO

Are you Anemic? □ YES □ NO

Have you had recent weight loss or loss of appetite? □ YES □ NO

Have you had or do you have any heart conditions (including HBP)? □ YES □ NO

Do you have any other medical conditions not listed above?

FAMILY HISTORY: Have any blood relatives had any of the following disorders?

- Diabetes □ YES □ NO
- High Blood Pressure □ YES □ NO
- Arthritis □ YES □ NO
- Heart Disease □ YES □ NO

Social History:

- Do you smoke? □ YES □ NO
- Packs per day? ____________
- Alcohol use? □ YES □ NO
- How often? ____________

The information is true and correct to the best of my knowledge:

Signature: ____________________________ Date: ________________