Medical History

Name:_____ **Date:**_____ ___**DOB:**_____

Height _____ Weight _____ Handedness - Right Left

Please list medications that you are allergic to, if any:

_____

Please circle if you have any of the following medical problems:

High Blood Pressure Heart Disease Arrhythmia Heart Attack Emphysema Asthma

Ulcer Hiatal Hernia Hepatitis Colitis Stroke Seizures Gout Previous Fracture

Diabetes Thyroid disease Cancer Blood Clots Bleeding Disorder

Other _____

Circle if you are experiencing any of the following:

Fatigue Blurry Vision Cough Chest Pain Abdominal Pain Incontinence

Hair Loss Dizziness Anxiety Rash Bruising

List prior surgeries and year:

_____

_____

List all medications you take (or provide a list):

_____ _____

_____ _____

_____ _____

_____ _____

Is there any possibility you are pregnant? YES NO

Circle if you are: Single Married Divorced Widowed

What is the name and location of your **pharmacy** ?_____

How much alcohol do you consume? _____

List use of tobacco products, amount per day, and years of use :_____

List any medical conditions that run in your family:_____