Medical History

Patient Name: _____ Birth date: _____

Visit Date: _____

PAST MEDICAL HISTORY:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune disorder
- ☐ BPH
- ☐ Blood clots
- ☐ COPD
- ☐ Cancer
- ☐ Cerebrovascular accident
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Gallbladder disease
- ☐ Heart murmur
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Myocardial infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Penile, testicular or prostate problems
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Stomach / Duodenal ulcer
- ☐ Thyroid disorder

FAMILY HISTORY: ☐ Adopted

Has anyone in your immediate family ever had any of the following disease? If so, please select the disease, person in your family and enter their age.

Medical condition:	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Anxiety								
ADD/ADHD								
Alcoholism								
Allergies								
Alzheimer's disease								
Asthma								
Autoimmune disease								
Blood pressure								
Coronary artery disease								
Cancer (specify below)								
CVA (stroke)								
Depression								
Developmental delay								
Diabetes								
Eczema								
Hearing deficiency								
High blood pressure								
High cholesterol								
Irritable bowel disease								
Learning disability								
Mental illness								
Migraines								
Obesity								
Osteoarthritis								
Osteoporosis								
PVD								
Renal (kidney) disease								
Seizure disorder								

Other family history:

_____

SURGICAL HISTORY: (list type and date):

_____

Medical History (cont.)

Tobacco use:

Have you ever used tobacco? ☐ No/never ☐ Yes Have you used tobacco in the last 30 days? ☐ No ☐ Yes

Have you used smokeless tobacco in the last 30 days? ☐ No ☐ Yes

Smoking Tobacco use:

Tobacco type:	Use daily:	Usage per day:	Years used:	Packs year:	Age started:	Age stopped:
Cigarette						
Cigarillo						
Cigar						
Pipe						

Non-Smoking Tobacco use:

Tobacco type:	Use daily:	Usage per day:	Years used:	Packs year:	Age started:	Age stopped:
Chewing						
Smokeless						
Snuff						

Vaping:

Have you ever vaped? ☐ No/never ☐ Yes

What is your current vaping status? ☐ Current user ☐ Not a current user

Device type: ☐ Advanced Personal Vaporizers (APVs) ☐ Disposable ☐ E-Cigar ☐ E-Cigarette ☐ Rechargeable ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Other

Current strength: ____% or _mg.ML

Vaping reason: ☐ Quit smoking ☐ Socializing ☐ Other _____

Alcohol:

Do you drink alcohol? ☐ No ☐ Yes ☐ Formerly

Type of alcohol: ☐ beer ☐ liquor ☐ wine

Frequency: ☐ daily ☐ weekly ☐ monthly ☐ yearly ☐ occasionally ☐ rarely ☐ socially Amount: _____

Last drink: ☐ today ☐ last night ☐ yesterday ☐ last week ☐ two weeks ago ☐ last month ☐ last year

How many times in the past year have you had 5 or more drinks in a day? _____

Drugs:

Any drug use? ☐ No ☐ Yes If yes, what kind of drug(s)? _____

Any illegal drug use? ☐ No ☐ Yes Use of marijuana? ☐ No ☐ Yes

Caffeine:

Do you drink/consume caffeine? ☐ No ☐ Yes Caffeine per day: _____

Type of caffeine: ☐ chocolate ☐ coffee ☐ energy drinks ☐ soda ☐ tablets ☐ tea

Lifestyle:

Changes in sleep patterns: ☐ No ☐ Yes Average number of hours of sleep per night: _____

Trouble falling asleep: ☐ No ☐ Yes Difficulty staying asleep: ☐ No ☐ Yes

Frequent waking episodes at night: ☐ No ☐ Yes

Disrupted breathing, gasping, gagging, or choking for air during sleep: ☐ No ☐ Yes

Activity level: ☐ moderate ☐ sedentary ☐ vigorous Health club member: ☐ Now ☐ Previously ☐ Never

Type of exercise: _____ Exercise frequency: _____ Hours/week _____

Animals in the home: ☐ No ☐ Yes - ☐ Birds ☐ Dogs ☐ Rodents ☐ Cats ☐ Reptiles ☐ Other _____

Do you clean up after the animals? ☐ No ☐ Yes

Do you have a religious affiliation? ☐ No ☐ Yes Do you practice your religion? ☐ No ☐ Yes

Is religion/spirituality an important part of your life? ☐ No ☐ Yes Do you have spiritual beliefs? ☐ No ☐ Yes

Do you agree to blood/blood products? ☐ No ☐ Yes

# of current sexual partners? _____ I use condoms: ☐ Always ☐ Sometimes ☐ Never

Medication Reconciliation

(Including vitamins, supplements and herbs)

Name of Medication:	**Dose:** **(example: 100mcg, 10mg, etc.)**	**Frequency:** **(example: once a day, before meals, etc.)**

Preferred pharmacy: _____

Allergies

(Medical, seasonal, food)

Name:	**Describe your reaction:**