Medical History

Patient Name: _____ **Birth Date:** _____

Date of Service_____

Past Medical History:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hypertrophy
- ☐ Blood clots
- ☐ COPD
- ☐ Cancer
- ☐ Cerebrovascular accident
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Gallbladder disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Myocardial infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Stomach / Duodenal ulcer
- ☐ Thyroid disease

Family History:

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

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
☐ ADD/ADHD	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Alcoholism	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Allergies	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Alzheimer's disease	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Asthma	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Blood disease	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ CAD	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ CAD – premature	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Cancer	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ 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 disease	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____
☐ Seizure disorder	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____	☐ ____

Other family history:

_____

Past Surgeries: _____

_____

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							**Non-Smoking Tobacco Use**					
Tobacco type:	Use daily:	Usage per day:	Years used:	Packs year:	Age started:	Age stopped:	Tobacco type:	Use daily:	Usage per day:	Years used:	Age started:	Age stopped:
Cigarette	□						Chewing	□				
Cigarillo	□						Smokeless	□				
Cigar	□						Snuff	□				
Pipe	□											

Vaping:

Have you ever vaped? □No/never □Yes What is your current vaping status? □Current user □Not a current user

What age did you start vaping? _____ What age did you stop vaping? _____

Device Type: □Advanced Personal Vaporizers (APVs) □Disposable □E Cigar □E-Cigarette □Rechargeable □Other

Frequency: □Daily □Weekly □Occasionally □Other

Current Strength:_% or_mg/ML Previous Strength:_____% or_____mg/ML and Duration: _____

Vaping reason: □Quit Smoking □Socializing □Other _____

Alcohol:

Do you drink alcohol? □No □Yes □Formerly

Type of alcohol: □beer □beer & liquor □beer & wine □gin □hard liquor □rum □scotch □vodka □whiskey □wine

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

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

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

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 animal? □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

Medication Reconciliation

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

Medical Allergies

Name of Medication	Describe your Reaction