Patient's Name:_____ Date: _____

Allergies/sensitivities to medication: _____

Current Medications(use back if needed):_____

_____

Past and Current Medical Conditions you have had(please circle):

Diabetes 1 or 2	Cancer:	Pneumonia	Stroke/TIA	Liver disease
Heart Attack/Stent	Thyroid ↑ or ↓	Autoimmune	Depression	Eye problems
Heart Surgery	Asthma	Blood clots	Anxiety	Infectious disease
↑ Blood Pressure	Seasonal Allergies	Bleeding tendency	Seizures	Erectile dysfxn
↑ Cholesterol	Sleep Apnea	Reflux	Kidney disease	Colon polyps

Other medical conditions/details not listed above: _____

_____

Past Surgeries: _____

_____

Family History – list illness in blood relatives – especially Heart, Diabetes, Cancer(type and age of onset), Blood pressure, Cholesterol, Thyroid, Dementia, Stroke, Depression/Anxiety, Kidney and Liver disease.

Mother:
Father:
Siblings:
Premature disease in 2nd degree(grandparents, aunts, uncles , cousins) relatives:

Lifestyle Habits:

Tobacco Use – Type and daily quantity:	# of years:
Alcohol Use – Servings and type per week:	
Caffeine Intake – Servings and type per day:	
Happy with current weight? Yes / No	If not please provide goal weight:
Exercise type, duration and frequency:	

Preventive Services:

Diseases immunized against and approximate date if known or circle → Conscientious Objector

Influenza:	Tetanus:	Pneumonia:	Shingles:

Last screening date if age/sex appropriate:

Pap smear(age 21-65 for females):
Mammogram(age 50 and above for females):
Colorectal cancer screening(age 50 and above):

Risk factors for Hepatitis C or other infectious/contagious diseases if applicable: _____

_____

Preferred Pharmacy(Retail and/or 90 day Mail-In): _____

Email address(if you would like mobile/computer access to lab results):_____