PATIENT'S MEDICAL HISTORY

Patient Name: _____ DOB: _____

MEDICATION HISTORY

Please list ALL the medications both prescription & over-the-counter,

and vitamins, minerals that you are currently taking

Name	Strength	Direction

ALLERGIES

Are you allergic to any medications? YES or NO

Are you allergic to Latex? YES or NO

Name	Reaction

VACCINATION HISTORY

VACCINATION	YES	NO	REFUSED
Influenza (Between August 1- March 31)			
Pneumonia (Age 65 and Over)			
Shingles			

HISTORY OF PREVIOUS TESTING

TEST	YES	NO	REFUSED
SYPHILIS			
GONORRHEA			

CHLAMYDIA			
HIV			
Screening for Hepatitis C			

MEDICAL HISTORY

List Major Injuries or Illnesses	Date

SURGICAL HISTORY

List Surgeries	Date

FAMILY HISTORY

Circle if any of your immediate family members have problems in the following areas:

Disease	Maternal Family Member	Paternal Family Member
Heart Disease		
Stroke		
Hypertension		
Cataracts		
Glaucoma		
Diabetes		
Thyroid Disease		
Arthritis		
Cancer		

SOCIAL HISTORY

Smoking History: **Current _____** **Former _____** **Never _____**

Do you presently use any of the following?	**YES**	**NO**
Chewing Tobacco		
Cigarettes, Cigars or Pipe		
Vaporless Cigarettes		
Do You Live with Someone Who Smokes		
Alcohol - If yes, Socially _____ Occasionally _____ Every day _____		
Recreational Drugs		
Drugs, If yes, daily		
Do you or have you ever taken Intravenous Drugs?		

If you presently smoke, are you interested in quitting smoking? **YES** **NO**

Do you feel you have an alcohol addiction? **YES** **NO**

Patient's Signature: _____ Date: _____