Date:__________

PATIENT HISTORY

Patient Name, DOB, Chart # (sticker)

Name: ____________________________________
Last   First

List all **medications, birth control, supplements, herbs, home remedies, vitamins** that you recently/currently take**:**

Do you now have or have you ***EVER*** had in the past:	(Office Use Only)
Allergies to Medications ☐no ☐yes: ___________________________ Surgeries ☐no ☐yes Hospitalizations ☐no ☐yes	
Lungs ☐no ☐yes Asthma ☐no ☐yes Positive TB test date:_________ Chest X-ray date:________ ☐no ☐yes Taken TB preventative meds? ☐no ☐yes Smoke: ☐ Cigarettes ☐ Hookah ☐ E-cigarettes/vaping How often:_____________________ Age began_________ Interested in quitting? ☐no ☐yes ☐no ☐yes Other lung problems:_______________________________	
Eyes-Ears-Nose-Throat Date of last eye exam:_________________ ☐no ☐yes Eye or vision problems ☐no ☐yes Environmental allergies:_____________________________ ☐no ☐yes Ear or hearing problems ☐no ☐yes Other:____	
Cardiovascular ☐no ☐yes Heart problems or murmur ☐no ☐yes High blood pressure ☐no ☐yes Other:____	
Gastrointestinal (stomach, intestines, liver, gallbladder) ☐no ☐yes Hepatitis or other liver problem ☐no ☐yes Heartburn (GERD) ☐no ☐yes Constipation ☐no ☐yes Other:____	
Hematologic (Blood disorders) ☐no ☐yes Anemia ☐no ☐yes Blood clots ☐no ☐yes Abnormal bleeding problem ☐no ☐yes Other:____	
Endocrine ☐no ☐yes Thyroid problems ☐no ☐yes Diabetes ☐no ☐yes Other:____	
Mental Health ☐no ☐yes Depression ☐no ☐yes Bipolar Disorder ☐no ☐yes Anxiety ☐no ☐yes ADD or ADHD ☐no ☐yes Eating disorder ☐no ☐yes Learning disabilities ☐no ☐yes Other:____	
Please complete back side of this form	

Patient Name, DOB, Chart # (sticker)

PATIENT HISTORY

Do you now have or have you ***EVER*** had in the past:	(Office Use Only)
Neuro ☐no ☐yes Seizure disorder (Convulsions) ☐no ☐yes Head injuries/concussions ☐no ☐yes Migraines (diagnosed) ☐no ☐yes migraines with visual changes ☐no ☐yes Other:____	
Genitourinary/Reproductive ☐no ☐yes Frequent urinary tract infections ☐no ☐yes Kidney problems ☐no ☐yes Problems in reproductive organs ☐no ☐yes Sexually transmitted infections (STI's) ☐no ☐yes Are you currently sexually active? With ☐male ☐female ☐both ☐no ☐yes Are you using any type of birth control method? ☐no ☐yes Are you using condoms for protection against STI's/pregnancy? ☐no ☐yes (women only) Abnormal Pap smear ☐no ☐yes (women only) Are you currently ☐ pregnant? ☐ breast feeding? ☐no ☐yes Other:____	
Other ☐no ☐yes Problems with bones or muscles ☐no ☐yes Broken bones? ☐no ☐yes Skin problems: ____ ☐no ☐yes Cancer:____ ☐no ☐yes Any other significant illnesses/injuries:______________________	
Vaccine history ☐no ☐yes Did you receive childhood vaccines? ☐no ☐yes Did you receive vaccines against Hepatitis? ☐Hep A ☐Hep B ☐no ☐yes Have you received the HPV vaccines? ☐no ☐yes Know date of your last Tetanus vaccine? Year: ____________ ☐no ☐yes Did you have chicken pox (Varicella) vaccine? ☐ Had disease ☐no ☐yes Do you get yearly flu vaccines?	
CURRENT Lifestyle ☐no ☐yes Exercise regularly? Type:______________________________ ☐no ☐yes Usually get at least 6-8 hours of sleep a night? ☐no ☐yes Cook your own meals? ☐no ☐yes Eat fruits and vegetables daily? ☐no ☐yes Visit a dentist regularly? ☐no ☐yes Recent loss or gain of weight more than 10 lb.? ☐no ☐yes Interested in losing weight? ☐no ☐yes Any dietary restrictions?________________________________ ☐no ☐yes Eat fast food daily? ☐no ☐yes Drink energy drinks? Number per week:_____________ ☐no ☐yes Drink alcohol? Number of drinks per week____________ ☐no ☐yes Use: ☐recreational drugs? ☐prescription drugs for fun? ☐IV drugs ☐no ☐yes Have you recently experienced any major life changes, sadness, loss, stress, or anxiety that interferes with your daily activities? ☐no ☐yes Are you having any experiences that make you feel unsafe? ☐no ☐yes Would you like more information about lifestyle issues?	

FAMILY History (Please include only	**parents, siblings, and grandparents)**	
☐no ☐yes Heart Attack before age 50 ☐no ☐yes High Blood Pressure ☐no ☐yes Diabetes	☐no ☐yes Stroke ☐no ☐yes High cholesterol ☐no ☐yes Mental Illness	☐no ☐yes Cancer:___________ **Other:**

Patient signature:____Date:___________________________

OFFICE USE ONLY: Reviewed by and date: