Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crack ☐ Methamphetamine

Are you allergic to any medications? ☐ Yes or ☐ No (If yes, please list.)

Current Medications	Dosage

Previous Surgery	Date

Have you ever had any of the following? Circle all that apply: ☐ Asthma ☐ Stomach Problems ☐ Bladder problems ☐ Jaundice-Liver ☐ Gout ☐ Alcoholism ☐ Kidney Disease ☐ Prostate ☐ Skin Disease ☐ Joint Disease ☐ Stroke ☐ Epilepsy-Seizures ☐ Depression-Anxiety ☐ Thyroid ☐ Blood Clot ☐ High Blood Pressure ☐ Tuberculosis ☐ Diabetes ☐ Cancer ☐ Lung Disease ☐ Heart Disease ☐ Psychiatric Disorder

Do any of these conditions run in your family? Circle all that apply: ☐ Alcoholism ☐ Addiction ☐ Joint Disease ☐ Stroke ☐ Blood Clots ☐ Diabetes ☐ Psychiatric Disorder ☐ Heart Disease

Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us? Circle any that apply:

Website ☐ Family/Friend ☐ Internet Search ☐

Former or current patient (please provide name so we can thank them!) _____

Physician (please specify): _____

Other Healthcare facility (please specify): _____

Insurance Network (please specify): _____

Other (specify): _____