

Name _____ Date of visit _____

Pertinent Medical History: Do you or have you ever had? If Yes, check the box.

- | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Autoimmune Disease | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> |
| Bleeding Disorder | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Back Problem | <input type="checkbox"/> | Migraines | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |
| Hiatal Hernia | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> |
| HIV | <input type="checkbox"/> | Thyroid Problems | <input type="checkbox"/> |
| Other, Not Listed _____ | | Transfusion of Blood | <input type="checkbox"/> |
| | | Treatment with Radiation | <input type="checkbox"/> |

Do you smoke? _____ If yes, how much? _____

Have you ever smoked? _____ If yes, when did you quit? _____

Do you drink alcohol? _____ If yes, how much? _____

If you did in the past, when did you quit? _____

Do you drink coffee? _____ If yes, how much? _____

Have you ever had surgery? If so, please list. _____

List the medications you are taking at present. _____

Any drug allergies? _____

Family History: If yes, check the box.

- | | | | |
|--|-----------------------------------|--|---------------------------------|
| High Blood Pressure <input type="checkbox"/> | Cancer <input type="checkbox"/> | Hearing Loss <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Heart Disease <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Condition(s) Similar to Yours <input type="checkbox"/> | |

Signature _____