Patient Name:	Account Number:

Your Medical History

Medical Conditions:

Previous Surgeries:

Current Medications:

Name	Dose	Directions (how often)

Do you have medication allergies? ☐ **Yes** ☐ **No** If yes, indicate below:

Preferred Pharmacy: _____

Do you smoke? ☐ **Yes** ☐ **No** If yes, how much? _____

Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, indicate how much:

☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Less than Monthly**

Family Medical History

If parent(s) are deceased, please indicate age(s) and cause(s) of death.

Mother?

Cause of Death Age

Father?

Cause of Death Age

In the spaces provided, please indicate who in your family has been diagnosed with the following medical conditions:

Arthritis?

Relationship

Autoimmune Disease?
(Rheumatoid Arthritis, Lupus, etc.)

Relationship Type

Relationship Type

Heartburn or GERD?

Relationship

Osteoporosis?

Relationship

Heart Disease?

Relationship

Hypertension?

Relationship

Diabetes?

Relationship

Cancer?

Relationship Type

Relationship Type

Relationship Type

Other Medical Conditions?

Relationship Type

Relationship Type

Relationship Type