Medical History

Name:____Date:__________________________

Reason for today's visit:_________________________________ Are you allergic to any medications? _________________________

List all medications you are currently taking: (If additional room is needed please use the back or make copies of your list)

1.____5.____

2.____6.____

3.____7.____

4.____8.____

Past/Current Medical Conditions

	Yes
High Blood Pressure	☐
Heart Disease/Stent	☐
Afib	☐
DVT / PE	☐
Diabetes / HgbA1C _______	☐
Anticoagulant / Blood thinner	☐
Antiplatelet /Aspirin / Plavix	☐
Crohns / UC	☐
Anxiety	☐
Major Depression	☐
MRSA / VRE Infection	☐
C. Diff Infection	☐

Past Surgeries:

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Other Medical Conditions:

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- Do you smoke tobacco? ___________If yes, how much? _________________If Quit, Date? _______________
- Do you drink alcohol? ___________If yes, how often? __________________If Quit Date? _______________
- Do you use marijuana? ___________If yes, how often? __________________If Quit Date? _______________
- Do you use Narcotics? ___________If yes, how often? __________________If Quit Date? _______________

Family History:	**Age**	**Disease**	**If Deceased, Cause**
Mom:	__________________	__________________________	_______________________________
Dad:	__________________	__________________________	_______________________________
Sibling:	__________________	__________________________	_______________________________
Sibling:	__________________	__________________________	_______________________________