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

Current Medications	Dosage

Previous Surgery	Date

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

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): _____