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): _____