[redacted]

Patient Name ______________________________ DOB: _________________________ Sex________

Allergies ____

Primary Care Provider ____

Medications (Include over the counter medications that you use)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Medical History

Previous Surgeries No Yes If yes, what type/when?: _______________________________________

Previous Hospitalizations No Yes If yes, what type/when?: _______________________________________

Headaches/Migraines No Yes Environmental/Seasonal Allergies No Yes

Diabetes No Yes High Cholesterol No Yes

High Blood Pressure No Yes Cancer No Yes

Seizures No Yes Anxiety No Yes

Depression No Yes Asthma/Breathing Problems No Yes

Blood/Immune System Problems No Yes Heart Problems No Yes

Liver or Kidney disease No Yes Thyroid Problems No Yes

Ae ycurdera bys,pcasbr healthcare pecscae fany problem?

If yes, please code period bef epato ____

Ae tree aybemlalpsalcdeswsbl tabo?

____

Social History

Cigarette Smoking: Never Previous, but quit When? ___________ Current packs per day ___________

Vaping or any other Tobacco products (including chew): Never Previous, but quit When? __________

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