PATIENT MEDICAL HISTORY **FD Initials:_____ Clinic Initials: _____**

Name: _____ Date of Birth: _____

Date: _____ Account #: _____

Pharmacy of Choice and location: _____ Phone Number: _____

CURRENT MEDICATION HISTORY

Please List **ALL** Medications you are presently taking (as well as over the counter, herbs, supplements)

☐ **NO MEDICATIONS**

Medication & Dosage	Frequency	Medication & Dosage	Frequency

PAST MEDICAL HISTORY

Do any of these Medical Problems below apply to you? Please check box to the left of those that apply.

☐ **No Past Medical History**
☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ AFib/Irregular/Fast Heartbeat
☐ Asthma
☐ Bleeding Tendency
☐ Blood Clots Where?:_____
☐ Cardiac Catheterization
☐ Cancer: Type: _____

☐ Chronic Leg Swelling
☐ Diabetes
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ MRSA

☐ Pacemaker Placement
☐ Seizures
☐ Shortness of breath
☐ Sleep Apnea CPAP?:_____
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis

☐ Active ☐ Remission

Other History:_____

Medication Allergies: _____**Yes** _____**No**

If yes, list medication(s) name & reaction(s): _____

_____

Allergies to: _____ Metal _____ Iodine _____ Shellfish _____ Latex _____None

Unusual reaction to Anesthesia?: _____Yes _____No If yes, please describe: _____

Please check or list ALL of your previous surgeries and indicate the year

☐ **NO SURGERIES**

☐ Appendectomy	Year:_____	Surgeon:_____	Other: List below
☐ Bypass/Open Heart	Year:_____	Surgeon:_____	Type of Surgery:_____
☐ Cataract Extraction	Year:_____	Surgeon:_____	Type of Surgery:_____
☐ Cesarean Delivery	Year:_____	Surgeon:_____	Type of Surgery:_____
☐ Gall Bladder	Year:_____	Surgeon:_____	Type of Surgery:_____
☐ Hernia Repair	Year:_____	Surgeon:_____	
☐ Hysterectomy	Year:_____	Surgeon:_____	
☐ Tonsillectomy	Year:_____	Surgeon:_____	
☐ Knee surgery	Year:_____	Surgeon:_____	Left: _____ Right:_____
☐ Shoulder surgery	Year:_____	Surgeon:_____	Left: _____ Right:_____
☐ Hip surgery	Year:_____	Surgeon:_____	Left: _____ Right:_____
☐ Neck surgery	Year:_____	Surgeon:_____	
☐ Back surgery	Year:_____	Surgeon:_____	

Please indicate the existence of the following conditions in your immediate family (parents, siblings, grandparents)

	Yes	No	Family Member
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Thyroid Disease			
Cancer: list			

Do you currently smoke? ____Yes ____No If no, have you ever smoked? ____Yes ____No

Use of e-cigarettes/vaping? ____Yes ____No

Do you drink alcohol? ____Yes ____No ____Socially

Illicit drug use? ____Yes ____No

Patient/Guardian Signature: _____