MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

Infectious Disease

- ☐ HIV/AIDS
- ☐ STD

Cardiac History

- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Hypertension

Endocrine

- ☐ Diabetes
- ☐ Graves
- ☐ Hashimoto's
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Parathyroid Disease
- ☐ Thyroid nodule(s)

Gastrointestinal

- ☐ Bowel Obstruction
- ☐ Crohn's
- ☐ Colon Polyps
- ☐ Diverticulosis
- ☐ Diverticulitis

Gastrointestinal Cont.

- ☐ Hemorrhoids
- ☐ IBS
- ☐ Reflux / GERD
- ☐ Ulcerative Colitis

GenitoUrinary

- ☐ Chronic UTI
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Prostate Problems
- ☐ Urinary Incontinence

Hematologic

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clots – leg/lung

Liver/Gallbladder

- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Hepatitis A/B/C

Muscle/Skeletal

- ☐ Arthritis
- ☐ Chronic Back Problems
- ☐ Fibromyalgia
- ☐ Hernia
- ☐ Osteopenia / Osteoporosis

Neurological

- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Bipolar
- ☐ Dementia
- ☐ Depression
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Stroke

Pulmonary

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Positive TB
- ☐ Sleep Apnea

Reproductive

- ☐ Endometriosis

Vascular

- ☐ Carotid Artery Disease
- ☐ Peripheral Arterial Disease
- ☐ Venous Insufficiency

- ☐ Other:
- ☐ Other:
- ☐ Other:
- ☐ Other:

Patient name: ______________________ DOB: ______________________

Surgical History

Procedure	Year	Procedure	Year
☐ Appendectomy	_______	☐ Pacemaker/Defibrillator	_______
☐ Breast Biopsy	_______	☐ Prostatectomy	_______
☐ Colonoscopy	_______	☐ Thyroidectomy	_______
☐ D&C	_______	☐ Tonsillectomy	_______
☐ EGD	_______	☐ Tubal Ligation	_______
☐ Gallbladder	_______	☐ Vasectomy	_______
☐ Hysterectomy	_______	☐ Other:	_______
☐ Hernia, Inguinal	_______	☐ Other:	_______
☐ Hernia, Ventral	_______	☐ Other:	_______
☐ Mastectomy	_______	☐ Other:	_______

Social History

Tobacco ☐ None ☐ currently smoke ___ packs/date and have done so for _____ years

☐ Previously smoked ____ packs/day for ____ years. Stopped in _____

☐ Smokeless Tobacco

Alcohol ☐ None

☐ Drinks per day ____ Week ____ Month_____ Year _____

Marijuana ☐ None ☐ Recreational ☐ Medical

Illegal ☐ None ☐ Cocaine ☐ Heroin ☐ Meth ☐ ________________

Caffeine ☐ None ☐ 1-3 Servings daily ☐ 3-6 Servings daily ☐ More than 6 servings daily

Personal History of Cancer

Type / Site of your cancer: ______________________ Date of diagnosis? _________________

What type of cancer treatment did you receive?

☐ Chemo Therapy When & Where: ________________________________

☐ Radiation Therapy When & Where: ________________________________

☐ Surgery When & Where: ________________________________

☐ Hormonal Therapy When & Where: ________________________________

Patient name: ___________________________________ DOB: ________________________________

Family History

Medical Conditions/ Cancer History ***If deceased; age of death & cause of death***

Father: ____________________

Mother: ____________________

Brother (s): ____________________

Sister (s): ____________________

Children: ____________________

Any other blood relatives with a history of **Cancer**? ____________________

Medication Allergies

Medication	*Reaction*

Do you have any problems with anesthesia? ☐ Yes ☐ No

Have you had an allergic reaction to tape? ☐ Yes ☐ No

Do you have an allergy to any latex products? ☐ Yes ☐ No

PLEASE BRING ALL YOUR MEDICATIONS

INCLUDING OVER THE COUNTER & VITAMINS

Patient name: ____________________ DOB: ____________________