Patient Health History

Full Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

How long have you had this issue? _____ How did it begin? _____

What helps relieve pain? _____ What worsens pain? _____

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 use any other illicit drugs? ☐ Yes ☐ No

Have you had any falls in the last year? ☐ Yes ☐ No How many? _____ Were you injured? ☐ Yes ☐ No

Current Medications	Dosage	Previous Surgery	Date MM/YY

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

Have you ever had any of the following? (Circle all that apply). Asthma, Stomach Issues, Bladder Issues, Jaundice, Liver Disorders, Gout, Kidney Disease, Skin Disease, Joint Disease, Stroke, Epilepsy, Seizures, Depression, Anxiety, Thyroid Issues, Blood Clots, 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, Arthritis, Stroke, Blood Clots, Diabetes, Psychiatric Disorder, Heart Disease

Is your mother still living? ☐ Yes ☐ No Is your father still living? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If yes, how many sons? _____ How many daughters? _____

Do you have siblings? ☐ Yes ☐ No If yes, how many brothers? _____ How many sisters? _____

Primary Care Physician Information

Name: _____ Phone Number: _____

***Pharmacy Information**

Name: _____ Phone Number: _____

Address: _____ City: _____ Zip: _____