



Medical History

Name _____ DOB _____ Male or Female _____

Allergies _____

Check all that apply: (Current or History of)

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease/Hypertension/CHF | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Asthma /COPD | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> History of bladder or urinary tract infections | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> GERD/Reflux disease | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Frequent Headaches |

Details and any other problems not listed:

Immunizations: Pneumonia? _____ Date _____ Annual Flu Shot? _____

Shingle (Herpes Zoster) ? _____ Date _____ Tetanus ? _____ Date _____

Are you currently being treated by other health care providers? For what condition?

Surgeries ? (Type and Date) _____

Significant Trauma ? (Auto accidents, falls, etc.) _____

Other pertinent information: _____

Signature of person completing this form:

_____ date: _____