Medical History

*Acct:*______________________
*Patient Name:*______________________________
*Referred By:*______________________________

For Internal Use ONLY	
Ht: ________	BP: ________
Wt:	P:

Past Medical History:(please print)

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Past Surgical History: (please print)

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Current Medications *(include over the counter Medications, Herbals and Vitamins)*

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Allergies: *(Please Check all that apply)*

________ *No Drug Allergy*	________ *Penicillin*	________ *Mycins*
________ *Codeine*	________ *IVP Dye*	________ *Cephalosporins*
________ *Tetracycline*	________ *Sulfa*	________ *ASA*
________ *Seasonal Pollen*	________ *Cipro*	________ *Insect Stings*

Other:____

Family History: *(Parents, sisters, brothers, grandparents)*

________ *Diabetes*	________ *Cancer*	________ *Stroke*
________ *Heart Attack/Agina*	________ *Epilepsy/Seizures*	________ *Kidney Disease*
________ *Tuberculosis*	________ *Arthritis*	________ *Ulcers*
________ *Gallbladder*	________ *Liver Disease*	________ *Hypertension*

Social History: *(Check all that apply)*

Have you used the following	*Alcohol*	*yes/no*	*How Often:*____________________
Have you used the following	*Tobacco*	*yes/no*	_____*packs per day* *Quit Y N Quit:*_____
Are you a substance abuser:		*yes/no*	