# MEDICAL HISTORY FORM

***The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.***

Name: _____ Date: _____ Age: _____

Do you have or have you had any of the following? (Check all that apply.)

- ❑ Seizure Disorder
- ❑ Stroke
- ❑ Spinal Nerve Compression
- ❑ Peripheral Neuropathy
- ❑ Broken Bones / Fractures
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Psoriatic Arthritis
- ❑ HIV
- ❑ Hepatitis
- ❑ Cancer Specify Type and Location _____
- ❑ Vision Loss
- ❑ Hearing Loss
- ❑ Unintentional Weight Loss
- ❑ Recent Weight Gain
- ❑ Hypertension / High Blood Pressure
- ❑ Prior MI / Heart Attack
- ❑ Coronary Artery Disease
- ❑ Peripheral Vascular Disease
- ❑ Deep Vein Throbosis
- ❑ Clotting Disorder
- ❑ Asthma
- ❑ Emphysema
- ❑ Bronchitis
- ❑ COPD
- ❑ Chronic Kidney Disease / Renal Insufficiency
- ❑ On Dialysis?
- ❑ Nephritis
- ❑ Nephrolithiasis / Kidney Stones
- ❑ Gastric Ulcer Disease
- ❑ Gastrointestinal Bleeding
- ❑ Gastro-esophageal Reflux
- ❑ Colitis
- ❑ Pancreatitis
- ❑ Cholelithiasis
- ❑ Diabetes
- ❑ Hyperthyroidism
- ❑ Other _____

PRIOR SURGERIES: _____

_____

CURRENT MEDICATIONS: _____

_____

Are you pregnant? _____Yes _____ No

## ALLERGIES TO MEDICINE

Are you allergic to any of the following? (Check all that apply.)

- ❑ No Known Allergy
- ❑ Penicillin
- ❑ Sulfa
- ❑ Codeine
- ❑ Latex
- ❑ Other _____

## HABITS

Please indicate current use of any of the following: Alcohol _____ Tobacco _____ Illegal Drugs _____

## FAMILY HISTORY

Has a family member been treated for any of the following? (Check all that apply and specify relationship using the codes listed in the box below.)

**Family Member Codes**

F = Father
M = Mother
S = Sibling
A = Aunt
U = Uncle
PGF = Paternal Grandfather
PGM = Paternal Grandmother
MGF = Maternal Grandfather
MGM = Maternal Grandmother

| | Family Member |
|---|---|
| ❑ Hypertension | _____ |
| ❑ Heart Attack | _____ |
| ❑ Diabetes | _____ |
| ❑ Arthritis | _____ |
| ❑ Gout | _____ |
| ❑ Stroke | _____ |
| ❑ Mental Illness | _____ |
| ❑ Epilepsy | _____ |

| | Family Member |
|---|---|
| ❑ Cancer | _____ |
| Type of Cancer | _____ |

_____

Patient / Guarantor Signature

***The above is true and correct to the best of my belief.***