Patient Past Medical History

Patient Name: ____ Date of Birth: ____________________

Allergies: ____

Current Medications (Include non-prescription medications):

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Personal Habits

Do you drink alcohol? ☐ **YES** ☐ **NO**

If YES ____ # drinks per ___ Day ___ Week ___ Month

Do you smoke or chew tobacco? ☐ **YES** ☐**NO**

If YES ____ # per ___ Day , ____ # years of use

Do you use E-Cigarettes? (vape) ☐**YES** ☐**NO**

If YES ____ # per ___ Day , ____ # years of use

Patient History Please check all that apply:

☐ Heart Disease ☐ Kidney, Bladder or Prostate Disease ☐Stroke ☐ Anxiety

☐ High Blood Pressure ☐ Joint Replacement ☐Seizures ☐ Depression

☐ High Cholesterol ☐ Liver Disease ☐ Nerve Impairment ☐ Skin Disorder

☐ Lung Disease ☐ Cancer (past or present) ☐ Spine Disorder ☐ Sleep Apnea

☐ Diabetes (1 or 2) ☐ Anemia or other blood disorder ☐ Sciatica ☐ Other _____________

☐ Hypoglycemia ☐ Blood Clots ☐ Migraine ____________________

☐ Thyroid Disorder ☐ Bleeding tendency ☐ Tuberculosis/TB ____________________

☐ Stomach Disease ☐ Bowel Disease ☐ Mental Health problems

Surgical History

☐ Tonsillectomy ☐ Wisdom Teeth ☐ Hysterectomy

☐ Appendectomy ☐ Plastic surgery ☐ Carpal Tunnel

☐ Gallbladder Removal ☐ Mastectomy (L/R) ☐ Spinal Surgery

☐ Myringotomy (ear tubes) ☐ Colonoscopy ☐ Orthopedic (including joint replacement)

Review of Current Symptoms

☐ Fever ☐Ear pain ☐Sinus congestion/drainage ☐ Cough/congestion ☐Nausea/Vomiting ☐Rash ☐Back pain

☐Urinary issues ☐Sore throat ☐Headache ☐Vision changes ☐Body aches ☐Other_______________________