

MEDICAL HISTORY

Patient Name: _____

Primary Care Physician: _____

PCP's office location:

Please list allergies to any medications:

Please list all of the medications that you take including tablets, capsules, sprays, creams, drops, and vitamins (prescription and over the counter):

Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Endocrine disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Mental illness | |
| <input type="checkbox"/> Fractures or lacerations of the facial area <input type="checkbox"/> Eye problems (including dryness if applicable) | | |

Please list any other current or past medical problems:

Please list any surgeries you have had (with approximate date):

Do you use tobacco? No Yes

Aspirin or Ibuprofen? No Yes

Do you drink alcoholic beverages? No Yes

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