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:

☐ High blood pressure	☐ Arthritis	☐ Cancer
☐ Stroke	☐ Endocrine disease	☐ Liver disease
☐ Diabetes	☐ Lung disease	☐ Bleeding disorder
☐ Heart disease	☐ Asthma	☐ Ulcers
☐ Seizure	☐ Mental illness	

☐ Fractures or lacerations of the facial area ☐ 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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