Patient Name (Please print): ______________________________ **Date of Birth:** __________________

Active Medications: *(If additional room is needed, please attach an additional sheet)*

Medication	Dosage	Directions

Allergies:
- ☐ No known allergies
- ☐ Allergies to medications ______________________________
- ☐ Other allergies ______________________________

Past Medical History:

Medical	Onset date		Onset date		Onset date
☐ Anemia		☐ Cerebral atherosclerosis		☐ Hypertension	
☐ Anesthesia reaction		☐ Cerebral Infarction		☐ Intracranial tumor	
☐ Angina		☐ Congestive heart failure		☐ Multiple sclerosis	
☐ Arrhythmia		☐ COPD		☐ Parkinson's disease	
☐ Asthma		☐ Coronary artery disease		☐ Peripheral nerve disease	
☐ Arthritis		☐ Diabetes		☐ Renal disease	
☐ Atrial Fibrillation		☐ Elevated lipids		☐ Seizure disorder	
☐ Blood clots		☐ Fibromyalgia		☐ Spinal cord tumor	
☐ Cancer		☐ Headache, migraine		☐ Stroke	
☐ Cardiac arrhythmia		☐ Hepatitis/liver disease		☐ Thyroid disease	
☐ Other ____________		☐ Other ____________		☐ Other ____________	

Surgical	Date		Date		Date
☐ Aneurysm clipping/resection		☐ Carpal tunnel release		☐ Knee replacement	
☐ Angioplasty		☐ Cataract extraction		☐ LASIK	
☐ Appendectomy		☐ Cerebral shunt		☐ Muscle biopsy	
☐ Arthrodesis		☐ Cholecystectomy		☐ ORIF	
☐ Spine surgery		☐ Colectomy		☐ Small bowel resection	
☐ CABG		☐ Colostomy		☐ Spinal infusion pump	
☐ Cardiac pacemaker		☐ Gastric bypass		☐ Thyroidectomy	
☐ Carotid endarterectomy		☐ Hernia repair		☐ Tonsillectomy	
		☐ Hip replacement		☐ Other ____________	

Family History: *(Immediate family only)*

	Who	Relationship		Who	Relationship
☐ ADD/ADHD			☐ CNS malignancy		
☐ Alcoholism			☐ Congestive heart failure		
☐ Alzheimer's disease			☐ COPD		
☐ Angina pectoris			☐ Coronary artery disease		
☐ Arthritis			☐ Crohn's disease		
☐ Asthma			☐ Dementia		
☐ Cancer			☐ Depression		
☐ Cardiovascular disease			☐ Developmental delay		

	Who	Relationship		Who	Relationship
☐ Diabetes	______	______	☐ Osteoporosis	______	______
☐ Elevated lipids	______	______	☐ Other movement disorder	______	______
☐ Fibromyalgia	______	______	☐ Parkinson's disease	______	______
☐ GI bleeding	______	______	☐ Peptic ulcer disease	______	______
☐ Headaches	______	______	☐ Peripheral vascular disease	______	______
☐ Hearing impairment	______	______	☐ Renal disease	______	______
☐ Hypertension	______	______	☐ Seizure disorder	______	______
☐ Inflammatory bowel disease	______	______	☐ Spinal cord tumor	______	______
☐ Kidney failure	______	______	☐ STD	______	______
☐ Learning disability	______	______	☐ Stroke	______	______
☐ Liver disease	______	______	☐ Thyroid disease	______	______
☐ Mental illness	______	______	☐ Tuberculosis	______	______
☐ Migraines	______	______	☐ Ulcerative colitis	______	______
☐ Myocardial infarction	______	______	☐ Other ______	______	______
☐ Obesity	______	______			

Social History:

☐ Non-tobacco user

☐ Tobacco What type: ______How many years? ______ Frequency? ______

Alcoholic beverages Yes ☐ No ☐

Occupation ______ Are you working?______ Last date worked ______

Please note your physical work requirements: Heavy ☐ Moderate ☐ Light ☐ Sedentary ☐

Do you have any children? Yes ☐ No ☐ How many?______

Preferred Pharmacy:

	Name	Telephone #	Location
Pharmacy 1:	______	______	______
Pharmacy 2:	______	______	______

Patient Signature ______ Date ______