

Patient Name: _____ Date: _____

Reason for today's visit: _____ Date of birth: _____ (age _____)

How did you hear about us?

Referred by: _____ May we thank them? YES NO Internet _____ Newspaper _____
(name of paper)

Medications

Please list all prescription medication (with dosage) that you are taking. Also include any herbal supplements, vitamins or non-prescription items _____

Do you take aspirin? Yes/No

Are you allergic to any medications: Yes/No If yes, list (& explain reaction: _____

Medical History

	Yes	No	If yes, please explain:
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs/Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscle/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family History	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood clotting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Do you vape?

Do you smoke? Yes/No

Do you use Cannabinoids? Yes/No

Do you drink alcohol? Yes/No

Females: Are you pregnant? Yes/No

Surgical History

Please list all surgeries or operations (including cosmetic that you have had):

Procedure:

Date:

