Patient History Form

Patient Name-		
Date of Birth-		
Social History-	**Married, Single or Divorced?**	**Sexually Active? Yes or No**

Current Smoker or Tabacco Use		**Yes**	**No**	**Never**	**Type?**		**# of yrs?**	
Current Alcohol Use		**Yes**	**No**	**Never**	**Freq?**		**Amount?**	
Personal & Family History-					Maternal		Paternal	
	Self	**Mom**	**Dad**	Bro/Sis	GM	GF	GM	GF
If deceased, list approx age of death-								
Neuro-								
Migraines								
Stroke								
Mental Health-								
Anxiety/Depression								
Drug/Alcohol Abuse								
ENT- Allergies								
Endocrine-								
Diabetes Type I or II								
Thyroid Disorder								
Cardiovascular								
High Blood Pressure								
High Cholesterol								
Resp- Asthma/COPD								
GI- GERD/REFLUX/ULCER								
Gynecology								
Endometriosis/PCOS								
Urology/Renal								
Kidney Stones/disease								
Cancers-								
Breast Cancer								
Colon Cancer								
Prostate Cancer								
Skin Cancer (type)								
Other-								
Viral History-								
Hepatitis- A, B or C								
Ebstein Barr/ Mono								
HSV I/HSV II								
Other Viral/STD History								
Other Medical Conditions-								

Ob/GYN History-	Last Menstrual Cycle-	Type Birth Control-
	Last Pap-	Last Mammo-
# of Pregnancies?	# of Vaginal Deliveries?	# of C-Sections?

Surgical History (list yr & type)

I certify the above information is correct to the best of my knowledge. I will not hold my provider or any staff member responsible for any error or omissions that I may have made during the completion of this form.

Signature-	**Date-**

Drug Allergies & Reaction-	

Current Medication List

Drug Name	**Dose**	**Freq.**

Current Supplement List

Supplement	**Dose**	**Freq.**

Preferred Pharmacy-