Name_____ Date: _____ Age: _____

REASON FOR VISIT:

_____

_____ WHEN SYMPTOMS BEGAN:

_____

_____

PREVIOUS TREATMENTS:

_____

_____

CURRENT MEDICATIONS (over-the-counter/prescription/herbal): NONE ▫

_____

_____

_____

_____

DRUG ALLERGIES: (please select one) YES ▫ NO ▫

If YES, please list here

_____

MEDICAL HISTORY (please check all that apply):

▫ Seasonal allergies

▫ Asthma

▫ Arthritis

▫Cancer (type)

▫ Chest pain

▫ Convulsions/ Seizures

▫ Diabetes

▫ Diarrhea

▫ Crohn's/Colitis

▫ Gall bladder trouble

▫ Gout

▫ Pregnant or Breastfeeding (currently)

▫ Headaches

▫ Heart murmur

▫ High blood pressure

▫ Infections

▫ Jaundice/ Hepatitis

▫ Mental illness

▫ Moodiness- Excessive

▫ Nausea/ Vomiting

▫ High cholesterol

▫ Osteoporosis

▫ Pneumonia

▫ Psoriasis

▫ Eczema

▫ Prostate Disease

▫Hives

▫ Stroke

▫ Thyroid disease

▫ Clotting Disorder

▫ Basal Cell Carcinoma

▫ HPV

▫ Venereal Disease

▫ Basal Cell Carcinoma

▫ Squamous Cell Carcinoma

▫ Contraceptive

_____

—

FAMILY HISTORY (please check all that apply):

▫ Asthma

▫ Bleeding Disorder

▫ Eczema

▫Seasonal Allergies

_____

▫Breast Cancer

_____

▫Ovarian Cancer

▫ Prostate Cancer

▫ Colon Cancer

▫ Basal Cell/ Squamous Cell Carcinoma

▫ Melanoma

Location/Relation: _____

SOCIAL HISTORY:

Alcohol:(please check one)

▫YES ▫ NO

Type: _____

Amount: (per week)

Smoking:(please select one)

▫YES ▫ NO

Packs Daily:

How long?