Health History

Name:	Date of birth:	Height:	Weight:
Reason for visit today:			
Do you smoke? ☐ Yes ☐ No	If yes, how many packs per day?		
Have you ever smoked? \square Yes \square	No If yes, when did you quit?		
Do you use alcohol? ☐ Yes ☐ No	If yes, how many drinks per week		
Do you or have you used the following in the last three months? Marijuana Cocaine Heroin Crack Methamphetamine			
Are you allergic to any medication	ns? Yes or No (If yes, please list.)		
Current Medications	Dosage	Previous Surgery	Date
Have you ever had any of the following? Circle all that apply: Asthma Stomach Problems Bladder problems Jaundice-Liver Gout			
Alcoholism Kidney Disease Prostate Skin Disease Joint Disease Stroke Epilepsy-Seizures Depression-Anxiety Thyroid Blood Clot			
High Blood Pressure Tuberculosis Diabetes Cancer Lung Disease Heart Disease Psychiatric Disorder			
Do any of these conditions run in your family? Circle all that apply: Alcoholism Addiction Joint Disease Stroke Blood Clots Diabetes			
Psychiatric Disorder Heart Disease			
Primary care physician information:			
lame: Phone number:			
Address:			
Pharmacy information:	n	h an a numah an	
	P		
Addiess			
How did you hear about us? Circle any that apply:			
Website Family/Friend Internet Search			
Former or current patient (please provide name so we can thank them!)			
Physician (please specify):			
Other Healthcare facility (please specify):			
Insurance Network (please specify):			
Other (specify):			