Name____ D.O.B.______________

HEALTH HISTORY

PLEASE CHECK "YES" IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWING CONDITIONS:

	Yes
Anxiety Disorder	
Asthma	
Back Problems	
Blood Pressure, HIGH	
Blood Pressure, LOW	
Cancer/Tumor	
Concussion/Head Injury	
Depression	
Diabetes	
Dizziness/Fainting	
Ear/Hearing Problems	
Heart Disease	

	Yes
Kidney Disorder	
Migraine	
Muscle/Bone Problems	
Palpitations	
Stomach/Intestinal Issues	
Seizures	
Substance Abuse	
Weight gain, unexplained	
Weight loss, unexplained	
Other (please list):	

PLEASE EXPLAIN ANY "YES" RESPONSES: ____
____

DO YOU HAVE ANY ALLERGIES? ◻ **Yes** ◻ **No**

If yes, please identify the specific type and what happens when you are exposed (if known):

◻ Medicine(s)____
◻ Environmental (i.e. pollen, dust, mold)____
◻ Stinging insects_________________________ ◻ Food______________________________________

MEDICINE(S): Please list all of the prescription and over-the-counter medicines and supplements (herbal and/or nutritional) that you are currently taking (with dosages if known): ____
____
____

HAVE YOU EVER HAD SURGERY? ◻ **Yes** ◻ **No**

If yes, please list type of surgery and date: ____
____

HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL/MENTAL HEALTH ISSUE? ◻ **Yes** ◻ **No**

If yes, please explain: ____

SOCIAL HISTORY

Do you smoke tobacco or have you ever smoked tobacco? ◻Never ◻Currently ◻Quit ◻Want to Quit

--If you currently smoke, how many packs per day do you smoke?_____________

--How long have you smoked?______________

--If you've quit smoking tobacco, when did you quit? _________________

Do you vape (i.e. use e-cigarettes, JUULs, etc.) ◻ Yes ◻ No If yes, how long have you vaped?____________

Do you chew tobacco? ◻ Yes ◻ No If yes, how long have you chewed tobacco? ______________________

Do you drink alcohol? ◻ Yes ◻ No If yes, how many drinks per week do you have? ________________

Do you use any street drugs (i.e. marijuana, cocaine) ◻ Yes ◻ No If yes, which drug? _________________

Rev. 7-2020