Date ___ / ___ / _____

Patient History Form

Name: ___________________________ Date of Birth: ___________________ Sex: ☐Male ☐Female

Did your doctor refer you here? ☐No ☐Yes If yes, referring Physician: ________________________________

Pharmacy Name and Location: ____

Hand Dominance: ☐Right ☐Left ☐Ambidextrous Occupation: ________________________________

Current Medications (Prescriptions, vitamins, supplements etc.):

____

____

____

Medication Allergies (please also list reaction if known):

____

____

Do you smoke cigarettes? ☐No ☐Yes How many packs per day?_________ For how many years?____________

Non-Cigarette Tobacco use:____

Do you consume alcoholic beverages? ☐No ☐Yes

On average, how many alcoholic beverages do you consume per week?_________________________________

Cardiovascular History:

Medical Conditions:

☐High Blood Pressure

☐High Cholesterol

☐A Fib (irregular heart rate)

☐Deep Vein Thrombosis (blood clot)

☐Coronary Artery Disease

☐Heart Attack

☐Heart Failure

☐Stroke

☐Heart Valve Disease

☐Vascular Disease

☐Other cardiac conditions or surgeries:

____

____

Surgeries:

☐Heart Bypass

☐Heart Stents

☐Pacemaker

Do you take blood thinners? ☐No ☐Yes

Do you have a cardiologist? ☐No ☐Yes

Cardiologist's Name: _________________________

☐ None apply

Pulmonary History:

Medical conditions:

☐Sleep Apnea

☐COPD

☐Asthma

☐Pulmonary Embolus (blood clot in lungs)

☐Other pulmonary history:________________

____

☐ None apply

Rheumatologic History:

☐Gout

☐Rheumatoid Arthritis

☐Psoriatic Arthritis

☐Lupus

☐Fibromyalgia

☐Lyme Disease

☐Other rheumatologic history: _____________

____

☐None apply

Date ___ / ___ / _____

Name: __________________________ Date of Birth: ___________________

Other Medical History:
☐Anxiety
☐Depression
☐Esophageal reflux/GERD
☐Stomach Ulcers
☐Kidney Disease
☐Liver disease
☐Osteoporosis
☐Enlarged prostate
☐Substance use disorder
☐Hepatitis
☐HIV/AIDS
☐Cancer (type)___________________________
☐Other: ________________________________
____
☐None Apply

Endocrine History:
☐Diabetes
☐Hypothyroidism
☐Hyperthyroidism
☐Other endocrine history: __________________
____
☐ None Apply

Family Medical History (Parents or Siblings):
☐Connective Tissue Disorder: ______________
☐Clotting Disorder: _______________________
☐Autoimmune Disease: ___________________
☐ None Apply

Past **Orthopedic** Surgeries (Please include dates and surgeon if known):
____
____
____
____
____

Past **Non-Orthopedic** Surgeries (Please include dates if known):
____
____
____
____
____

Please return to the desk once completed in order to be checked in for your appointment.