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Medical History

Patient Name:_____ Date:_____
How is your general health? □Excellent □Good □Fair □Poor
Have you seen a physician within the last year? □Yes □No Reason:_____
Are you still being treated: □ Yes □No
Tobacco use: Current:□ Yes □No Former: □Yes □No **If yes:** Cigarette ( ) Cigar ( ) Pipe ( ) Chewing ( ) Dipping ( )
Do you drink alcohol? □Yes □No **If yes:** Type:_____ Social ( ) Occasional ( ) Light ( ) Heavy ( )

Do you have any known **allergies**? (Ex. Medications, Adhesives, Latex, Shellfish, etc.?) □Yes □No
Please list: _____
Do you use, or have you used IV/other recreational drugs? □Yes □No

Height: _____ Weight: _____ Shoe size: _____

Females: Are you pregnant? □Yes □No How many months?_____

Please check all that apply: If you have or have had any of the following health concerns:

□ Anemia	□ Anxiety	□ Arthritis	□ Asthma
□ Back_____	□ Cancer_____	□ COPD	□ Cholesterol High
□ Dementia	□ Depression	□ Dermatitis	□ Diabetes
□ Epilepsy	□ GERD	□ Glaucoma	□ Gout
□ Headache	□ Hepatitis	□HIV	□ Hypertension
□ Migraine	□ MI(Heart Attack)	□ Stroke	□ Thyroid
□ TB	□ Ulcer (Foot)	□ Ulcer (Leg)	□ Ulcer (GI)
□ Varicose Veins	□ Vascular Disease	□_____	□_____

Family History: (Parents, Brothers, Sisters, and/or Children)

□ Anemia	□ Cancer	□ Vascular Disease
□ Diabetes	□ Heart Disease	□ High Blood Pressure

Father: Age_____ □ Alive □ Deceased **Mother:** Age_____ □ Alive □ Deceased

Current Medications: (Please list or provide a copy of your medications including dosage)
_____
_____
_____
_____

Please include any information not requested that you feel important: (Example: Surgeries, illnesses etc.)
_____

_____

Signature:_____