****

**Name: Date of Birth:**

**Today’s Date:**

**Medical History:** (Please circle previous or current medical conditions)

 None Anemia Diabetes Liver Disease

 Arthritis Heart Disease/CAD Osteoporosis

 Asthma Hepatitis Prostate

 Blood Clots/DVT High Blood Pressure Stomach Ulcer/Acid reflux

 Cancer High Cholesterol Stroke/Seizures

 COPD/Lung Disease HIV/AIDS Thyroid Disease

 Depression Irregular Heartbeat Vascular Disease

 Other

**Surgical History:** (Please list ALL previous surgeries/operations and the dates performed)

 None

**Current Medications:** (Please list names of all drugs and doses/amounts you are taking)

 None

**Allergies to Medications/food:** Have you experienced an allergic reaction to any prescription drugs or food?

 No Yes Name of drug/food?

**Social History:**

Do you smoke? No Yes : packs/day for years

Do you drink alcohol? No Rare Socially Daily

Do you use illicit drugs? No Yes:

**Family History of Medical Conditions:** (Please list any medical problems that run in your family)

 Mother: alive deceased – Medical conditions: None

 Father: alive deceased – Medical conditions: None