Medical History

Do you take prescription medication?   Y / N

List medication and dose: (**Bring medication in original bottles to appointment**)

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____

List all over the counter medication, name and dose: (**please bring in original container to appointment**)

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____

Do you have any allergies to food or medication? Please List:

____
____

Please list any past surgeries and the date of surgery:

____
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Have you or an immediate family member* been diagnosed with the following:

*** S-self, M-mother, F-father, MGM-Maternal grandmother, MGF-maternal grandfather, PGM-paternal grandmother, PGF-paternal grandfather, SB- sibling**

☐ High Blood Pressure _________	☐ Diabetes _________	☐ Heart Disease _________
☐ Asthma _________	☐ Tuberculosis _________	☐ Thyroid Disease ________
☐ Kidney Disease _________	☐ Arthritis _________	☐ Anxiety _________
☐ Depression _________	☐ Osteoporosis _________	☐ Migraines _________
☐ Blood Disorder _________	☐ Cancer _________	☐ Sickle Cell Anemia _________
☐ Heart Murmur _________	☐ Seizures _________	☐ Stroke _________

☐ Other: ____

Mothers Age: ________________ Alive Y / N   Fathers Age: __________________ Alive Y / N

Cause of death: __________________________   Cause of death: ________________________________

# of Brothers: ________________ # of brothers living: _______________ Cause of death: _________________________

# of Sisters: _________________ # of sisters living: _________________ Cause of death: _________________________

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