MEDICAL HISTORY

Insurance Information

Be sure to take all insurance and prescription cards with you to the appointment.

Insurance Provider: ____________________

Account Number: Group Number: ____________________

Policy Holder's Name: ____________________

Patient's Relationship to Insured: ____________________

Secondary Insurance Provider: ____________________

Account Number: Group Number: ____________________

Policy Holder's Name: ____________________

Patient's Relationship to Insured: ____________________

Policy Holder's Employer: ____________________

Employer Address: ____________________

Employer Phone Number(s): ____________________

Past Medical History

In the past has the patient been diagnosed with any of the following? Check all that apply.

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Clots (for example, thrombosis)
- ❑ Cancer
- ❑ Colitis
- ❑ Concussion
- ❑ Depression
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol level
- ❑ HIV/AIDS
- ❑ Impaired Mobility
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Migraines
- ❑ Sexually Transmitted Diseases (STDs)
- ❑ Urinary Tract Infection
- ❑ Other: ____________________

MEDICAL HISTORY

List any previous surgeries, imaging, hospitalizations or other major procedures.

PROCEDURE	DESCRIPTION/PURPOSE	DATE

MEDICAL HISTORY

Family Medical History

Has anyone in the patient's family experienced any of the following? If so, who?

ASTHMA	
BLOOD CLOTS (FOR EXAMPLE, A THROMBOSIS)	
CANCER (LIST TYPES)	
DEPRESSION	
DIABETES	
HEART DISEASE	
HEPATITIS	
HIGH BLOOD PRESSURE	
HIGH CHOLESTEROL LEVEL	
LOW BLOOD PRESSURE	
KIDNEY DISEASE	
LUNG DISEASE	
IRRITABLE BOWEL SYNDROME	
LIVER DISEASE	
COLITIS	
HIV/AIDS	
OTHER	

MEDICAL HISTORY

Current Medications and Allergies

Please list all of the medications the patient is taking. Include, any vitamins, supplements or over-the-counter medications.

MEDICATION NAME	DOSAGE/FREQUENCY	REASON TAKEN

List all allergies including those to medications, foods and environmental allergens:

____

____

Pharmacy

Pharmacy Name: ______________________________

Phone Number(s): ______________________________

Fax Number: ______________________________

Address: ______________________________