Medical History

Please complete as briefly as possible.

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Patient Information

Name: _____ Date of birth: _____ Date: _____

Allergies

Medication / food / other allergies: _____

Current Medications

List prescription medications, over-the-counter medications, and supplements. Include dose if known.

Medication	Dose	How Often

Medical Conditions

Check any that apply: ☐ High blood pressure ☐ Heart problems ☐ Diabetes ☐ Seizures ☐ Asthma/COPD ☐ Liver problems ☐ Kidney problems ☐ Hepatitis ☐ HIV ☐ Other

Other medical conditions or important history: _____

Surgeries / Hospitalizations

Procedure / Reason	Approx. Year

Tobacco / Nicotine

☐ Never ☐ Current ☐ Former Type: ☐ Cigarettes ☐ Vaping ☐ Other Amount / frequency: _____

Primary Care / Emergency Contact

Primary care provider: _____ Phone: _____

Emergency contact / relationship: _____ Phone: _____

I certify that the information above is accurate to the best of my knowledge.

Patient signature: _____ Date: _____