Date: _____

PATIENT NAME: _____ DOB: _____

PAST MEDICAL HISTORY: High Blood Pressure, Diabetes: type 1 or type 2-, Heart Disease, Cancer or other conditions:

_____

PAST SURGICAL HISTORY: _____

_____

DO YOU HAVE A PACEMAKER OR ANY OTHER METAL IMPLANTED IN YOUR BODY? YES NO

If so please describe. _____

FAMILY HISTORY: Please circle all that apply.

High Blood Pressure: Mother Father

Diabetes: Mother Father

Heart Disease: Mother Father

Stroke: Mother Father

Epilepsy/Seizures: Mother Father

Cancer: Mother Father

Migraine/Headaches: Mother Father

HABITS/SOCIAL HISTORY:

Tobacco Usage: Cigarettes, smokeless tobacco, cigars: current every day smoker/user, current some day smoker/user, former smoker/user, never smoker/user. If current, how many/much per day: _____

Caffeine Usage: YES NO If yes how frequent/how many per day? _____

Alcohol usage: YES NO If yes, how frequent/how many per day? _____

Other Drugs: YES NO If yes, substance/how often? _____

IS ILLNESS OR INJURY WORK RELATED? Yes No If yes please describe with date of injury: _____

_____

DRUG ALLERGIES: _____

PHARMACY NAME AND LOCATION: _____

Brief description of the reason for your visit today: _____

_____