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# MEDICAL HISTORY FORM

**(Please print legibly)**

Name: _____

DOB: _____SS #: _____

Previous physician: _____ Date of last physical exam: _____

**Current or past medical conditions** (check all that apply)

Heart disease (Congestive heart failure, Atrial fibrillation, Murmurs, Heart Attack, Angina) ☐
Hypertension/High blood pressure ☐
Nutritional deficiency (B12, Vitamin D, Calcium) ☐
Seasonal allergies/hay fever/perennial allergies (animal dander, dust, mold) ☐
Lung disease (Asthma, COPD – Chronic Bronchitis, Emphysema) ☐
Vascular disease (atherosclerosis, Peripheral vascular disease, DVT, blood clots) ☐
Diabetes (Type 1, Type 2, Pre-diabetes, metabolic syndrome, gestational diabetes) ☐
Thyroid disease (Grave's disease, hyperthyroid, hypothyroid, thyroiditis) ☐
**Female only** - Gynecological conditions (endometriosis, fibroids, irregular periods, hot flashes) ☐
**Male only** - Prostate conditions (prostate enlargement, frequent urination, difficulty urinating) ☐
Gastrointestinal disease (Acid reflux, inflammatory bowel disease, constipation, diverticulitis) ☐
Kidney/Renal disease (Chronic kidney disease, polycystic kidney disease) ☐
Musculoskeletal (Osteoporosis, arthritis, fibromyalgia, herniated disk, Myasthenia gravis) ☐
Neurological disease (Neuropathy, seizures, Parkinson disease, dementia, MS, headaches) ☐
Anemia/Blood disorder (Sickle cell disease, Fe deficiency anemia, myeloproliferative disorder) ☐
Autoimmune disease (Lupus, connective tissue disorder, rheumatoid arthritis, vitiligo) ☐
Psychiatric/mental health (Depression, anxiety, bipolar disorder, schizophrenia, OCD, BPD) ☐
Infectious diseases (HIV, Hepatitis C, Tuberculosis, Herpes) ☐
Cancer (Please specify type) _____ ☐
Other Medical Conditions (Please describe): _____

_____

Is there a family history of the above listed conditions? ☐N ☐Y (Please explain) _____

_____

_____

_____

_____

Have you ever had **surgery** or been **hospitalized**? ☐N ☐Y (Please describe) _____

_____

_____

_____

**Vaccination History**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| MMR | ☐N | ☐Y | Polio | ☐N | ☐Y | Hepatitis B | ☐N | ☐Y |
| Tetanus | ☐**N** | ☐**Y** | Pertussis | ☐**N** | ☐**Y** | Varicella | ☐**N** | ☐**Y** |

**Medication History**

Please list all currently **prescribed medications** and how often you take them (example: Dilantin 3x/day) **Do not include medications that you may be currently misusing – there will be a place to list them later.**

_____

_____

_____

_____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc., and how often you take them: _____

_____

_____

_____

_____

Please list any **allergies** you have (e.g., penicillin, bees, or peanuts):_____

_____

**Substance Use History**

**Tobacco History:**

**Do you currently smoke?** ☐N ☐Y **If no, did you previously smoke?** ☐N ☐Y, Quit date _____

**Cigarettes** ☐N ☐Y how many _____ for how long _____

**Cigars** ☐N ☐Y how many _____ for how long _____

**Do you currently chew/dip?** ☐N ☐Y **If no, did you previously chew/dip?** ☐N ☐Y, Quit date _____

| | No | Yes/Past Or Yes/Now | Route (orally, snorted, smoked, injected) | How Much | How Often | Date/Time Of Last Use | Quantity Last Used |
|---|---|---|---|---|---|---|---|
| Alcohol (beer, wine, liquor, malt beverages) | | Past ☐ Now ☐ | | | | | |
| Caffeine (energy pills or energy drinks) | | Past ☐ Now ☐ | | | | | |
| Cocaine/crack/freebase | | Past ☐ Now ☐ | | | | | |
| Methamphetamine | | Past ☐ Now ☐ | | | | | |
| Heroin | | Past ☐ Now ☐ | | | | | |
| Inhalants (solvents, aerosol sprays, gases, nitrites) | | Past ☐ Now ☐ | | | | | |
| Hallucinogens (Mushrooms, ayahuasca, mescaline/peyote) | | Past ☐ Now ☐ | | | | | |
| Marijuana (Cannabis) | | Past ☐ Now ☐ | | | | | |
| Club drugs (GHB, Rohypnol, Ecstasy, Molly, LSD, ketamine) | | Past ☐ Now ☐ | | | | | |
| Opioids (Tramadol, methadone, Kratom Hydrocodone, oxycodone) | | Past ☐ Now ☐ | | | | | |
| Dissociatives (PCP, Salvia, Dextromethorphan/DXM) | | Past ☐ Now ☐ | | | | | |
| Stimulants (Adderall, Ritalin, methamphetamine, dextroamphetamine) | | Past ☐ Now ☐ | | | | | |
| Sedatives (Xanax, Valium, Ativan, barbiturates) | | Past ☐ Now ☐ | | | | | |
| Anabolic steroids | | Past ☐ Now ☐ | | | | | |
| Cathinones (“Bath salts”, Khat) | | Past ☐ Now ☐ | | | | | |
| Synthetic cannabinoids (Spice/K2) | | Past ☐ Now ☐ | | | | | |

Did you ever stop using any of the above substances because of dependence? ☐N ☐Y (Please list) _____

_____

_____

Have you ever been **treated for substance misuse**? ☐N ☐Y (Please describe when, where and for how long)

_____

_____

_____

What was your longest period of abstinence after treatment or voluntarily stopping use? _____

_____

Are you receiving, or have you ever received counseling support for substance use? ☐N ☐Y (Please describe when and for how long) _____

_____

_____

**Lifestyle and Wellness History**

| | |
|---|---|
| **Do you exercise regularly?** | ☐N ☐Y, (how often) |
| One to two times a week? | ☐ |
| Two to three times a week? | ☐ |
| Three to five times a week? | ☐ |
| Five to seven times a week? | ☐ |
| **What is your workout regimen (select all that apply)?** | |
| Cardio (cycling, running, dancing, walking, hiking, cross fit, HIT) | ☐ |
| Weight/resistance training | ☐ |
| Yoga | ☐ |
| Tai Chi | ☐ |
| Martial arts | ☐ |
| Other (please describe) | ☐ |

_____

**How would you describe your diet (select all that apply)?**

Standard American (Highly processed foods, fast foods, all animal and plant products) ☐

Mediterranean (Predominantly vegetable and grains with limited animal products) ☐

Pescetarian (Plant based diet with fish, may also eat dairy and/or eggs) ☐

Vegetarian (Plant based diet with egg and/or dairy products) ☐

Vegan (Plant based diet with no animal products) ☐

Raw Food (Vegan diet with no processed or cooked foods) ☐

Paleo (Natural unprocessed foods, grain-free meats, no grains or sugars –except fruit) ☐

Ketogenic **(**High fat, adequate protein, low carbohydrates) ☐

Sugar-free ☐

Gluten-free ☐

Low/No Carbohydrate ☐

Other (please describe) ☐

_____

_____

**Are you religious or spiritual?** ☐N ☐Y

**If so, describe your religious or spiritual practice?**

_____

_____

_____

_____

**Do you wear your seat belt while driving?** ☐N ☐Y, _____% of the time

**Do your drink alcohol and drive a motorized vehicle?** ☐N ☐Y, _____% of the time

**Do you have unprotected sexual activities (oral, anal or vaginal)?** ☐N ☐Y, _____% of the time

**Are you in an abusive relationship (physically, emotionally or verbally)?** ☐N ☐Y

**If yes, please describe:** _____

[6]