Medical Information Form

Name:____ Date of Birth:___________________ Age: __________

Address: ____, City__________________________________,
State:_________, Zip code_____________

Cell Phone: _______________________________ Other Phone: ____

Email: ____

Emergency Contact Name & Number:

____

Primary Care Physician (or referral) and Phone number to
Contact____

Do you have any allergies? If Yes, what?   Yes   No

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____

Have you had any anesthesia problems with you or your family members?   Yes / No

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Hight:__________________________, Weight:________________________________.

Medical History (Check all that apply):

Migraines	Coronary Artery Disease	Asthma	Diabetes
Headaches	Heart Attack	COPD/Emphysema	Thyroid Insufficiency
Stroke, TIA	Carotid Artery Disease	GERD/Stomach Ulcer	Liver Disease
Hypertension	Irregular Heart Beat, A-fib	Hiatal Hernia	Kidney Disease Insufficiency or Failure
High Cholesterol	Blood Disorder	Arthritis	Smoking

Cancer (type and treatment):

____

____

Mental Health Conditions (Check all that apply):

	Self	Mother	Father	Siblings	Not Applicable
DEPRESSION					
ANXIETY					
PTSD					
SUICIDALITY					
ALCOHOL ABUSE					
DRUG ABUSE					
EPILEPSY					
BIPOLAR					
PSYCHOSIS					
RSD/CRPS					
FIBROMYALGIA					
CHRONIC PAIN					

Any other health condition, not mentioned above:

____

Social History: Marriage status: _________________ Children? _________________

Do you exercise regularly? Yes / No

Are you happy with your weight? Yes / No

Are you concerned about your alcoholic intake? Yes / No

List any non-prescription drug use: ____

____

List all medications currently taking: (Drug Name, Dose, Prescribing Doctor)

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____

Do you have any discontinued medications? Yes / No

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In the last year have you drank alcohol or used drugs more than you meant to? Yes / No

Have you wanted/needed to cut down on your drinking or drug use in the last year? Yes / No

In the last year have you used alcohol or non-prescription drugs to deal with feelings of frustration or stress?
Yes / No

As a result of drinking or drug use has anything happened in the last year that you wished hadn't happened?
Yes / No

Describe any other stressors in your life:

____

____

Life History Suicide Attempt Yes / No