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| **Name:** | **Date of Birth:**  |
| **Reason for visit:** | **Occupation:** |
| **Marital Status (circle):** Married /Single/Widowed /Divorced /Separated**Any religious or cultural preferences you would like us to know**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Alcohol Use:** Y/N how much/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Caffeine Use**: Y/N how much/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Recreational Drug Use (drug/how often)**: Yes/No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Drug Allergies:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Food Allergies:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Sexual Orientation (circle):** Heterosexual/Homosexual/Bisexual Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Exercise:** None OR Exercise type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days/week \_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes/day**Diet Type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Current Health Status (circle):** Excellent/Good/Fair/Poor |
| **Surgical History:**

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**Family History: Please Note Condition /Relation**

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| Cancer (type): |
| Diabetes: |
| Heart Disease: |
| Hypertension:  |
| Other: |
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| **Current Complaints/Reason to be seen**  |
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 | **Past Medical History:**

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**Current Medications Prescribed and OTC to include vitamins, herb, supplements:**

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Preferred Pharmacy: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_