Medical History

Please complete before your first visit so we can review it with you. Leave blank and write “none” rather than skipping a section.

Patient Name & Date of Birth

Name	Date of birth	Today's date

Current Medications

List all prescriptions, over-the-counter medicines, vitamins, and supplements, with dose and frequency if known.

Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency

Allergies

Medication / food / other allergies and the reaction

Past Medical History

Check all that apply and note the approximate year of diagnosis where relevant.

- ■ High blood pressure
- ■ Diabetes
- ■ High cholesterol
- ■ Heart disease
- ■ Asthma / COPD
- ■ Thyroid disease
- ■ Depression / anxiety
- ■ Cancer
- ■ Kidney disease
- ■ Liver disease
- ■ Autoimmune disease
- ■ Other (describe below)

Other conditions

Past Surgeries / Hospitalizations

Procedure / reason	Year

Procedure / reason	Year
Procedure / reason	Year

Family History

Significant conditions in parents, siblings, or grandparents (e.g. heart disease, diabetes, cancer)

Social History

- Tobacco use — current ■ former ■ never ■
- Alcohol use — regularly ■ occasionally ■ never ■
- Occupation:

I confirm the information above is accurate to the best of my knowledge and I will update the practice of any changes to my medications, allergies, or health history.

Patient / Guardian signature	Date