Medical History

Do you take prescription medication? Yes? ☐ No? ☐

List medication and dose: (**Bring medication in original bottles to appointment**)

_____

_____

_____

List all over the counter medication, name and dose: (**please bring in original container to appointment**)

_____

_____

_____

Do you have any allergies to food or medication? Please List:

_____

_____

_____

Please list any past surgeries and the date of surgery:

_____

_____

_____

Have you or an immediate family member* been diagnosed with the following:

*** S-self, M-mother, F-father, MGM-Maternal grandmother, MGF-maternal grandfather, PGM-paternal grandfather, PGF-paternal grandfather, SB- sibling**

☐ High Blood Pressure _____	☐ Diabetes _____	☐ Heart Disease _____
☐ Asthma _____	☐ Tuberculosis _____	☐ Thyroid Disease _____
☐ Kidney Disease _____	☐ Arthritis _____	☐ Anxiety _____
☐ Depression _____	☐ Osteoporosis _____	☐ Migraines _____
☐ Blood Disorder _____	☐ Cancer _____	☐ Sickle Cell Anemia _____
☐ Heart Murmur _____	☐ Seizures _____	☐ Stroke _____

☐ Other: _____

Mother's Age: _____ Alive Yes? ☐ No? ☐ Father's Age: _____ Alive Yes? ☐ No? ☐

Cause of death: _____ Cause of death: _____

# of Brothers: _____ # of brothers living: _____ Cause of death: _____

# of Sisters: _____ # of sisters living: _____ Cause of death: _____