NAME_____ **DOB**_____

PATIENT HEALTH HISTORY INFORMATION

PLEASE CIRCLIF IF **YOU** HAVE A HISTORY OF ANY OF THE FOLLOWING:

Arthritis	YES	NO	High Blood Pressure	YES	NO
Atrial Fibrillation	YES	NO	High Cholesterol	YES	NO
Congestive Heart Failure	YES	NO	Hypothyroid	YES	NO
Coronary Artery Disease	YES	NO	Prostate Enlargement	YES	NO
Diabetes	YES	NO	Pulmonary Embolism	YES	NO
Deep Vein Thrombosis	YES	NO	Seizures	YES	NO
GERD/ Reflux	YES	NO	Stroke	YES	NO
Heart Attack	YES	NO	Trouble Sleeping	YES	NO

Chronic Kidney disease YES NO Stage:_____
Cancer: (Lung, Breast, Colon, Prostate, Etc.) YES NO DETAILS_____
Lung Disease: (Asthma, Emphysema, COPD) YES NO DETAILS_____
Psychiatric Illness: (Depression, Anxiety, Bipolar) YES NO DETAILS_____

Marital Status: Married____ Single___ Divorced___ Separated___ Widowed___ Other___

Do you live alone or with partner/family? _____

FAMILY HISTORY	**YES**	**NO**	**FAMILY MEMBER**
Cancer			_____
Diabetes			_____
Hypertension			_____
Psychiatric Illness			_____

Please List all Surgeries_____
_____
Other Illnesses not listed above_____
_____
Allergies_____

Do you currently smoke cigarettes? YES___NO___ Do you smoke Marijuana: YES__ NO__
Did you smoke in the past? YES__ NO___ If yes, number of years _____ number of packs per day____
Quit date_____

Do you/did you drink alcohol? YES NO If yes how much_____ Quit date_____

Do you/did you ever use recreational drugs? YES NO If yes what kind_____ Quit date_____

Current Medications (dosage and how taken): _____
_____
_____

Medical Power of Attorney (person to make decision if you can't) _____
NAME PHONE NUMBER

Alternate Medical Power of Attorney_____
NAME PHONE NUMBER