

Reason for Visit and Referring Physician

Medical History

Heart disease	Seizures	Asthma	Arthritis	Hearing loss
High blood pressure	Stroke	Thyroid disease	Osteoporosis	Vertigo
High cholesterol	Depression	Hemophilia	Liver disease	Glaucoma
Diabetes	Anxiety	Anemia	Kidney disease	Cancer (list type)

Surgical History

Medications

Allergies (to medications)

Family History

Heart disease	Seizures	Asthma	Arthritis	Hearing loss
High blood pressure	Stroke	Thyroid disease	Osteoporosis	Vertigo
High cholesterol	Depression	Hemophilia	Liver disease	Glaucoma
Diabetes	Anxiety	Anemia	Kidney disease	Cancer

Social History

Tobacco: _____ packs/day for _____ years. Quit _____ years ago.

Alcohol: Daily / Occasionally

Recreational Drugs (please list): _____

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