Chief complaint: What is the reason for your visit today? _____

_____

Past Medical History: (list any medical problems that other doctors have diagnosed)

☐ High blood pressure ☐ Alzheimer's/ Dementia ☐ Diabetes (sugar) ☐ Cancer ☐ Depression ☐ Anxiety ☐ Seizures/Epilepsy

☐ Stroke ☐ Migraine/Headache ☐ Heart disease ☐ Other _____

Have you had Blood work, MRI, CT Scan, EMG, EEG? ◯ Yes ◯ No If so, WHEN & WHERE: _____

_____

Surgeries/Operations: Year:

List your prescribed Medications and Over-the-Counter meds, such as vitamins & inhalers: (name, dosage, & directions/frequency)

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

Allergies to medications: (name of medication & reactions) _____

_____

Caffeine: ☐ none ☐ coffee ☐ tea ☐ soda # of cups/cans per day: _____

Illicit Drugs: Do you currently or have you ever used recreational or street drugs? ◯ yes ◯ no
Have you ever given yourself street drugs with a needle? ◯ yes ◯ no

Tobacco: Do you currently or have you ever used tobacco products? ◯ yes ◯ no # of years _____ or year quit _____
☐ Cigarettes - pks/day _____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____ ☐ Cigars - #/day _____

Alcohol: ☐ never ☐ occasional ☐ moderate ☐ heavy
How many drinks might you have in a typical week? _____ ☐ Beer ☐ Wine ☐ Liquor ☐ Other _____

Current weight: _____ lbs. **weight loss/gain in the last year: + / -** _____ lbs. **average # of meals/day:** _____

Height: _____ ft. _____ in.

Family History:	age	age at death	Significant health problems or cause of death			age at death	Significant health problems or cause of death
Father				Grand-Parents	Maternal		
Mother					Paternal		
Brother (s)				Children	Son (s)		
Sister (s)					Daughter (s)		

Has anyone in your immediate family had:

High Blood Pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Heart Disease	◯ Yes ◯ No	Depression/anxiety	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Migraine	◯ Yes ◯ No