Date	/	/	
Date	/	/	

Patient History Form

Name:	Date of Birth:		Sex: □Male □Female			
Did your doctor refer you here? □No □Yes If yes, referring Physician:						
Pharmacy Name and Location:						
Hand Dominance: □Right □Lef	t □Ambidextrou	IS	Occupation:			
Current Medications (Prescriptions, vitamins, supplements etc.):						
Medication Allergies (please also list reaction if known):						
Do you smoke cigarettes? □No □Yes How many packs per day? For how many years? Non-Cigarette Tobacco use: Do you consume alcoholic beverages? □No □Yes On average, how many alcoholic beverages do you consume per week?						
Cardiovascular History: Medical Conditions: High Blood Pressure High Cholesterol A Fib (irregular heart rate) Deep Vein Thrombosis (blood Coronary Artery Disease Heart Attack Heart Failure Stroke	□Heart Stents □Pacemaker		Pulmonary History: Medical conditions: □Sleep Apnea □COPD □Asthma □Pulmonary Embolus (blood clot in lungs) □Other pulmonary history: □ None apply			
□ Heart Valve Disease □ Vascular Disease □ Other cardiac conditions or surgeries: □ Do you take blood thinners? □ No □ Yes Do you have a cardiologist? □ No □ Yes Cardiologist's Name: □ None apply		_	Rheumatologic History: Gout Rheumatoid Arthritis Psoriatic Arthritis Lupus Fibromyalgia Lyme Disease Other rheumatologic history:			
□ Νοτίς αρ ρ ιγ			□None apply			

Other Medical History: □ Date of Birth: □ Anxiety □ Diabetes □ Depression □ Hypothyroidism □ Stomach Ulcers □ Other endocrine history: □ Liver disease □ Other endocrine history: □ Stomach Ulcers □ None Apply □ None Apply □ Connective Tissue Disorder: □ Connective Tissue Disorder: □ Clotting Disorder: □ Autoimmune Disease: □ None Apply □ None Apply □ None Apply □ Past Non-Orthopedic Surgeries (Please include dates if known): □ Past Non-Orthopedic Surgeries (Please include dates if known):			Date / /
Other Medical History: Anxiety	Name:	Date of Rirth:	
□ Diabetes □ Diabetes □ Hypothyroidism □ Hyperthyroidism □ Diabetes □ Hypothyroidism □ Diabetes □ Diabete	Nume.		
□ Diabetes □ Diabetes □ Hypothyroidism □ Hyperthyroidism □ Diabetes □ None Apply □ Diabetes	Oth or Madical History		Endosvino History
Depression	-		-
□ Esophageal reflux/GERD □ Stomach Ulcers □ Kidney Disease □ Liver disease □ Osteoporosis □ Enlarged prostate □ Substance use disorder □ Hepatitis □ HIV/AIDS □ Cancer (type) □ □ Clotting Disorder: □ □ Autoimmune Disease: □ None Apply Past Orthopedic Surgeries (Please include dates and surgeon if known): □ Past Non-Orthopedic Surgeries (Please include dates if known):	•		
Stomach Ulcers	•		
Connective Tissue Disorder: Connective Tissue Disorder: Connective Tissue Disorder: Clotting Disorder: Clotting Disorder: Clotting Disorder: None Apply Past Orthopedic Surgeries (Please include dates and surgeon if known): Past Non-Orthopedic Surgeries (Please include dates and surgeon if known): Clotting Disorder: Clott			
□ Liver disease □ Osteoporosis □ Enlarged prostate □ Substance use disorder □ Hepatitis □ HIV/AIDS □ Cancer (type) □ Other: □ None Apply □ None Apply □ None Apply □ Past Orthopedic Surgeries (Please include dates and surgeon if known): □ Past None Apply □ Past No			☐Other endocrine history:
□Osteoporosis □Enlarged prostate □Substance use disorder □Hepatitis □Cancer (type) □Other: □None Apply □None Apply Past Orthopedic Surgeries (Please include dates and surgeon if known): □Past None Apply □ Past None Apply	•		
□Enlarged prostate □Substance use disorder □Hepatitis □HIV/AIDS □Cancer (type) □Other: □None Apply □None Apply □ Past Orthopedic Surgeries (Please include dates and surgeon if known): □Enlarged prostate □Substance use disorder: □Connective Tissue Disorder: □Clotting Disorder: □Autoimmune Disease: □None Apply □ None Apply □ Past Non-Orthopedic Surgeries (Please include dates dates if known): □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			☐ None Apply
Substance use disorder Hepatitis Connective Tissue Disorder: Clotting Disorder: Autoimmune Disease: None Apply Past Orthopedic Surgeries (Please include dates and surgeon if known): Past Non-Orthopedic Surgeries (Please include dates include date	□Osteoporosis		
Hepatitis	☐Enlarged prostate		
□ Cancer (type) □ Clotting Disorder: □ □ Clotting Disorder: □ □ Autoimmune Disease: □ None Apply Past Orthopedic Surgeries (Please include dates and surgeon if known): □ Past Non-Orthopedic Surgeries (Please include dates dates if known):	☐Substance use disorder		
Cancer (type)	□Hepatitis		Family Medical History (Parents or Siblings):
Cancer (type)	□HIV/AIDS		□Connective Tissue Disorder:
Past Orthopedic Surgeries (Please include dates and surgeon if known): Description Description	□Cancer (type)		
Past Orthopedic Surgeries (Please include dates and surgeon if known): Description Description	□Other:		□Autoimmune Disease:
Past Orthopedic Surgeries (Please include dates and surgeon if known): Past Non-Orthopedic Surgeries (Please include dates if known):			
and surgeon if known): dates if known):	□None Apply		
and surgeon if known): dates if known):			
and surgeon if known): dates if known):			
and surgeon if known): dates if known):			
and surgeon if known): dates if known):			
	Past Orthopedic Surgeries (Please include	e dates	Past Non-Orthopedic Surgeries (Please include
	and surgeon if known):		dates if known):

Please return to the desk once completed in order to be checked in for your appointment.