Medical History Intake Form

Patient Name DOB SEX M F

Reason For Visit

Occupation:

Primary Care Doctor

Family Medical History

Do You Have Any Allergies To Medication Yes or No

If Yes Please List

Do You Take Any Medication Yes or No

If Yes Please List

Do You Have Any Of The Following Medical Problems

Asthma	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Stroke	Yes	No
Heart Attack	Yes	No
Seizures	Yes	No
Cancer	Yes	No

Please List Any Other Medical Problems

Have You Ever Had Surgery Before Yes No

If Yes Please List Surgeries

Alcohol Yes No

Smoke Cigarettes Yes No Quit

If Yes Please Specify How Many Per Day/Week

If Yes For How Many Years

If You Quit Please List Quit Date

*******For Staff Use Only*******

TEMP	**HR**	**RESP**	**BP**
O2	**Pain**	**HT**	**WT**