

Name: _____ Date of Birth: _____

Primary Physician: _____ Referring Physician: _____

Pharmacy : _____ Town: _____

History of Substance Abuse: _____ Yes _____ No What type? _____

Do You Smoke? _____ Yes _____ No Amount: _____ When did you quit? _____

Do you use Alcohol? _____ Yes _____ No Amount: _____ Type: _____

Do you have any Allergies to Food or Medications? _____ Yes _____ No Describe: _____

Have you or a BLOOD Relative had any of the following:

	YES	NO	WHO
Congestive Heart Failure			
Atrial Fibrillation			
Coronary Artery Disease			
High Cholesterol			
Hypertension			
Heart Attack			
Asthma			
COPD			
Sleep Apnea			
Reflux			
Hepatitis			
Acute Renal Failure			
Chronic Renal Failure			
Kidney stones			
Diabetes			
Hypothyroidism			
Arthritis			
Osteoporosis			
Stoke			
T.I.A.			
Parkinson's			
Alzheimer's			
Anemic/ Low Iron			
Sickle Cell			
Glaucoma			
Cancer			
Type			

Past Surgical History: Please list ALL surgeries and dates