Updated Medical History

Patient Name: _____ **Date of Birth**:_____

Height_____ **Weight**_____ BMI:_____

Who Is Your Primary Care Physician:_____

List Medical Problems You Have or Had:

_____
_____
_____
_____
_____

List All Medications You Take

_____
_____
_____
_____
_____

List Surgeries You Have Had

_____
_____

List Allergies to Medications

_____
_____

Can you take Anti-inflammatory Drugs (Ibuprofen, Aleve, Aspirin)? YES NO

List Any Medical Problems in Your Family

_____
_____
_____

What Hobbies Do You Have?_____
Do You Play Any Sports Regularly?_____
Do You Exercise?_____

Please Mark the Appropriate Answer:

Yes	No		Yes	No	
•	•	Weight loss or Gain	•	•	Asthma
•	•	Wound healing problems	•	•	Pneumonia
•	•	Psoriasis	•	•	Stomach Ulcers
•	•	Depression	•	•	Acid Reflux
•	•	Blood clots	•	•	Prostate problems
•	•	Bleeding Problems	•	•	Urinary infections
•	•	Heart attack	•	•	Fibromyalgia
•	•	High blood pressure	•	•	Gout
•	•	Stroke	•	•	Hepatitis
•	•	Sciatica	•	•	AIDS
•	•	Diabetes	•	•	Osteoporosis
•	•	Cancer	•	•	Taken Prednisone
•	•	Drink Alcohol	•	•	Use Recreational Drugs
☐	☐	Pneumonia Vaccine	☐	☐	Colon Screening (Colonoscopy)
☐	☐	Flu Vaccine			

Tobacco Use: ☐ever ☐ormer ☐ccasional ☐veryday ☐ight ☐eavy

Signature:_____ **Date:**_____