Patient Name:_____ Date of Birth_____

Family Physician:_____ Referred by:_____

Patient History: Do you have or ever had any of these, please check yes or no:

	Yes	No		Yes	No		Yes	No
Hearing Problems	☐	☐	Asthma/Bronchitis	☐	☐	Psychiatric Care	☐	☐
Vision Problems	☐	☐	Blood Transfusion	☐	☐	Hepatitis/Jaundice	☐	☐
Fractures/Dislocations	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐
Arthritis/Back/Neck	☐	☐	Thyroid Problems	☐	☐	Cancer/Chemo/Radiation	☐	☐
Heart Problems/Chest Pain	☐	☐	Gastrointestinal Problems	☐	☐	Anesthesia Complications	☐	☐
Heart Murmur	☐	☐	Rectal Bleeding	☐	☐	Bleeding Disorders/Anemia	☐	☐
Ankle/Leg Swelling	☐	☐	Kidney/Urinary Bleeding	☐	☐	Chance of Pregnancy	☐	☐
Blood Pressure Problems	☐	☐	Stroke/Seizures	☐	☐	Others:_____		
Poor Circulation/Arms/Legs	☐	☐	Dizziness/Fainting	☐	☐	_____		

Past Surgical History: Have you ever had any of these surgeries?

	Yes	No		Yes	No
Gallbladder	☐	☐	Cesarean Section	☐	☐
Appendix	☐	☐	Breast Biopsy	☐	☐
Thyroid	☐	☐	Hysterectomy	☐	☐
Hernia	☐	☐	Other_____		

Please Check the Correct Answer:

	Yes	No		
Do you smoke?	☐	☐	Cigarettes/Pipe/Cigar	Amount/Day_____# of Years_____ Quit Date_____
Do you drink alcohol?	☐	☐	Type_____	Amount/Day_____# of Years_____ Quit Date_____
Recreational Drugs?	☐	☐	Type_____	Amount/Day_____# of Years_____ Quit Date_____

List any food or medication allergies:_____

_____

Medications: Include non-prescription drugs, inhalers, contraceptives, supplements you take now.

Drug	Dose	How Often	Reason for taking	Check if Currently Using		Last Dose