Patient Name:___________________________________ **Date of Birth:**_________________________

Current Medications

*****Please bring all of your current medications with you to your appointment or a current list with name, dosage, directions and prescribing physician listed. This will assist us in taking care of you and your healthcare needs.

Allergies to Medications?

____
____

Past Medical History

Diabetes _____Yes _____No When diagnosed? ______________________________
High blood pressure _____Yes _____No
High cholesterol _____Yes _____No
Thyroid disorder _____Yes _____No
Osteoporosis _____Yes _____No
Heart disease _____Yes _____No
Liver disease _____Yes _____No
Kidney disease _____Yes _____No
Depression _____Yes _____No
Stroke _____Yes _____No
Cancer _____Yes _____No If yes, what type? ______________________________
Other medical history ____
____

Surgical History - Type and year (if known)

____
____
____

Family Medical History (not your medical history but your family)

	Yes	No	**Relationship to you** (father, mother, brother, etc.)
Diabetes			
Hypertension			
High cholesterol			
Heart disease			
Stroke			
Thyroid disease			
Osteoporosis			
Cancer (if yes, what kind?)			
Other endocrine disorder			

Social History

Do you smoke? ____Yes ____No If yes, number of packs per day and number of years ____________________
Do you drink alcohol? ____Yes ____No If yes, number of drinks per week ______________________________
Do you use recreational drugs? ____Yes ____No If yes, what kind and how often _________________________
Marijuana use? ____Medical _____Social _____No