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Patient Medical History

Please fill out this form completely. The following information will help us in providing you the best medical care and treatment possible. If you have any questions, please contact the office. Thank you and we look forward to seeing you.

Patient Information

Last Name *

Date of Birth *

MM/DD/YYYY

Medical History

Please list all medications you are currently taking (including over-the-counter and vitamins/supplements) *

One per line. Enter NONE if you aren't taking anything.

Please list any allergies *

One per line. Enter NONE if you don't have any allergies.

Please check all the apply *

- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Diabetes
- [ ] Seizure
- [ ] Asthma
- [ ] Depression
- [ ] Mental Illness
- [ ] Stroke
- [ ] Hypothyroidism
- [ ] Cancer
- [ ] None

Type of Cancer

If applicable

Other Conditions

If not specified above

Social History

Do you smoke? *

-- Please Select --

How many cigarettes per day?

If applicable

Any other forms of tobacco? *

-- Please Select --

List other forms of tobacco

If applicable. Please enter one form per line

Do you drink alcohol? *

-- Please Select --

How often?

If applicable

Do you use any other drugs?

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List other drugs

If applicable. Please enter one drug per line

Family History

Does anyone in your family (living or deceased) have any of the following conditions:

Please check all that apply *

- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Diabetes
- [ ] Seizure
- [ ] Asthma
- [ ] Depression
- [ ] Mental Illness
- [ ] Stroke
- [ ] Hypothyroidism
- [ ] Cancer
- [ ] None

Type of Cancer

If applicable

Other Conditions

If not specified above

Surgical History

Please select or list all surgeries that you have had.

Please check all that apply: *

- [ ] Appendix
- [ ] Tonsils/Adenoids
- [ ] Hysterectomy
- [ ] Gallbladder
- [ ] C-Sections
- [ ] Heart
- [ ] None

Other surgeries

If not specified above

Patient Medical History will be submitted to **COLLABORATEMD**

Submit

*You have **10** required fields to fill out. Click here to show them.*