Patient Medical Information

Patient Name: _____

Please list all **ALL** medications including their strength and frequency or provide a list:

_____

_____

_____

_____

_____

_____

Please list any **allergies/reactions** you may have to medications, food, or environmental allergies:

_____

_____

_____

Please list any **sugeries or hospitalizations** in your past: _____

_____

_____

Do you smoke? _____ If so, how long? _____ How much? _____
Do you drink **alcoholic beverages**? _____ If so, how oftern? _____
Do you **exercise** at least 150 minutes per week? _____ Are you **sexually active**?_____
Do you use **caffeine**?_____ What and how much? _____

Please list all immediate **family medical history** (parents, siblings, children, etc.) _____

_____

_____

_____

Race (circle all that apply): Native American or Alasakan Native / Asian / Native Hawaiian / African American / Caucasian / Hispanic / Other _____

Are your **employed**? _____ Where _____ **Retired**?_____

Circle: **Married / Divorced / Single / Separated** **Children?** # and ages _____

Please do not leave any blanks. Put N/A if anything doesn't apply. Thank you!

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