

History Intake Form

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History Intake Form

Date of Birth: Name: **MEDICAL HISTORY** Please indicate all conditions you have experienced □ BPH **Heart Disease** Bone Density Scan/ DEXA:____ ☐ Allergies Hypothyroidism Hyperthyroidism ☐ Asthma Females: **High Blood Pressure** ☐ Anxiety Disorder ☐ Currently pregnant ☐ Cancer- Specify: **Elevated Cholesterol** Number of: ☐ COPD Migraines ____Pregnancies ☐ Crohn Disease Osteoarthritis ___Live Births ☐ Depression Stroke/CVA Miscarriages Abortions Diabetes- Type 1 ☐ Urinary Disorders ☐ Mammogram_____ ☐ Diabetes- Type 2 ☐ Other: Pap Smear ☐ Epilepsy/Seizures Do you see any specialists for these conditions? If so, List Below: Specialist: _____ Condition: _____ Specialist: _____ Condition: _____ Specialist: Condition: **SURGICAL HISTORY** Please list all past surgeries including the date □ Colonoscopy _____ Date: Date: _____ Date: Date: _____ Date: _____ Date: FAMILY HISTORY Please list all chronic health issues your immediate family members have Chronic Illnesses: Deceased: Father: Mother: Brother: Sister: Maternal Grandmother: Maternal Grandfather: Paternal Grandmother:

Paternal Grandfather:

Other: