

Clinic ID: _____

Clinic Location: _____

Date: _____

Patient Name: _____ Gender: Male / Female

Age: _____ Height: _____ Weight: _____

Do you use tobacco? No Yes If yes, how many packs/day? _____

Do you drink alcohol? No Yes

If yes, how often? (circle one) Rarely / Occasionally / 1-2 drinks per day / >2 drinks per day

Do you use IV or illicit drugs? No Yes

Are you allergic to any medications? No Yes

If yes, please list: _____

Does your mother, father, brother(s) or sister(s) have any of the following?

Diabetes	No	Yes	Hyperlipidemia	No	Yes
High Blood Pressure	No	Yes	Heart Problems	No	Yes
Reactive Airway Disease	No	Yes	Kidney Problems	No	Yes
Coronary Artery Disease	No	Yes	Liver Problems	No	Yes
Other (please list) _____					

Do you have or have you had any of the following?

_____ Diabetes	_____ Cancer, type: _____ When? _____
_____ High Blood Pressure	_____ Depression
_____ Coronary Heart Disease	_____ Lung disease
_____ Reactive Airway Disease	_____ Asthma
_____ Asplenia	_____ Kidney problems
_____ Congestive Heart Failure	_____ Liver problems
_____ Heart Attack	_____ Ulcers-stomach, esophagus
_____ Emphysema or chronic bronchitis	_____ Immunosuppression
_____ Parkinson's disease	_____ Stroke
_____ Heart problems	_____ Environmental/Seasonal allergies
_____ Angina	_____ Other (please list) _____
_____ Anemia	_____ Recent ER/Hospital/Surgery Date: _____
_____ Blood clotting disorder	_____ Last Menstrual Period: _____
_____ Headache/Migraines	_____ Is there any chance you may be pregnant? _____

Are you currently taking any medication? No Yes (circle one) If yes, please list:

Name of Medication **Reason for taking this medication**

