PATIENT MEDICAL HISTORY · STEPAHEADCHELSEA.COM

Thank you for visiting our office. Please check all that apply to you.

Patient Name _____ **Age** _____ **Date of Birth** _____

PLEASE CHECK ALL THAT APPLY TO YOU:

- ❑ I have no medical conditions
- ❑ Acid Reflux
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Bladder Disease
- ❑ Blood Clots
- ❑ Blood Disorders (Sickle cell)
- ❑ Bronchitis
- ❑ Cancer (type)
- ❑ Depression
- ❑ Diabetes (how many years?)
- ❑ Epilepsy
- ❑ Gastric Ulcers
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Vascular Disease
- ❑ Other Medical Conditions: _____

MEDICATIONS (*list names only*)

❑ I take no medications ❑ Medication list provided by patient

_____

_____

Are you currently taking any herbal medications or vitamins? ❑ I use no herbal medications or vitamins

❑ I take the following herbal medications or vitamins: _____

ALLERGIES

❑ I have no drug allergies

- ❑ Aspirin
- ❑ Antibiotics (*list below*)
- ❑ Anti-inflammatory
- ❑ Iodine
- ❑ Codeine
- ❑ General Anesthesia
- ❑ NSAIDS
- ❑ Latex
- ❑ Local Anesthesia
- ❑ Sulfa
- ❑ Pain Meds (*list below*)
- ❑ Penicillin
- ❑ Shellfish
- ❑ Tape
- ❑ Other Medication Allergies: _____

FAMILY HISTORY (*diabetes, heart disease, gout, cancer, foot problems or other*)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

SURGERIES + HOSPITALIZATIONS (*procedure, year and any complications*)

_____

_____

IMPLANTS/ARTIFICIAL JOINTS/PACEMAKER (*please list*)

_____

Height _____ **Weight** _____ **Shoe Size** _____ ❑ Medium ❑ Narrow ❑ Wide

Do you consume alcohol? ❑ No ❑ Yes (*if so, how many drinks/beers in a week?* _____)
Do you smoke? ❑ No ❑ Yes (*if so, number of packs/day* _____ *for* _____ *years)*
Did you ever smoke? ❑ No ❑ Yes (*if so, how much?* _____ *packs/day for* _____ *years, quit in* _____)

I certify that the above information is true and correct to the best of my knowledge.

Patient/Guardian Signature _____ **Date** _____