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**Annual Medical History Form**

**Date:**

**Name: DOB:**

1. **Have you had any changes with medical history in the past year?** YES or NO

 **If so, please list:**

1. **Have you had any changes with surgical history in the past year?** YES or NO

**If so, please list:**

1. **Do you see any new Specialist?** YES or NO

**If so, please list:**

1. **Do you have any new allergies to food or drug?** YES or NO

**If so, please list:**

**MEDICATION LIST**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **HOW OFTEN** | **DISEASE/REASON** | **PRESCRIBED BY** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please list **ALL** prescription and non-prescription medications. This includes vitamins, herbal medicine, supplements, birth control pill, inhales and over the counter medications.

**Preferred Local Pharmacy**

**Name: Phone Number:**

**Address:**  **City: State: Zip:**

 **Mail order Pharmacy**

**Name: Phone Number:**

**Address:**  **City: State: Zip:**

**PLEASE SEE THE REVERSE SIDE OF FORM FOR COMPLETTION**

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**Annual Medical History Form**

**FAMILY HISOTRY**

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY MEMBER** | **AGE** | **LIVING** | **CAUSE OF DEATH** |
| Father |  |  |  |
| Mother |  |  |  |
| Brother(s) # |  |  |  |
| Sister(s) # |  |  |  |

**Only need to complete if anything has changed in the past year.**

|  |  |  |  |
| --- | --- | --- | --- |
| * Arthritis
 | * Cancer
 | * Depression
 | * High Cholesterol
 |
| * Addiction Problems
 | * Breast Cancer
 | * Diabetes
 | * Kidney Disease
 |
| * Anxiety
 | * Colon Cancer
 | * Heart Disease
 | * Liver Disease
 |
| * Bleeding Problems
 | * Prostate Caner
 | * High Blood Pressure
 | * Mental Illness
 |

**DISEASES IN THE FAMILY** (check all that apply)

**SOCIAL HISTORY**

**Do you live:** Alone with a spouse or partner with family other

**Who do you rely on for support and help?**

**Do you smoke?** Currently: packs/day years Past: Date quit: Never

**Do you use a vape pen?** Currently Never

**Do you use an e-cigarette?** Currently Never

**If you smoke, are you interested in quitting?** YES NO

**Other nicotine use?** YES NO

**Exposure to secondhand smoke?** YES NO

**Do you drink alcohol?** YES NO Beer Wine Liquor **How many drinks per week?**

**How many caffeinated beverages per day?** Coffee Tea Soda Energy Supplements

**Any recreational drug use?** YES NO **Type?**

**Do you exercise regularly?**  YES NO **If so, how many times per week? Type of exercise?**

**Do you feel safe in your home?** YES NO

**How many hours of sleep do you get per night? Do you wake up feeling well rested?** YES NO

**Please sign below to indicate the above information is accurate to the best of your knowledge**

**Patient Signature:**  **Date:**