

MEDICAL INFORMATION

Name: _____ DOB _____ Age _____ Date: _____

What problem brought you to our office? _____

Are you under the care of a physician? Yes _____ No _____ Physician _____

Referred by _____ Current Occupation _____

Do you have a Living Will? Yes _____ No _____

DO YOU HAVE ANY OF THE FIVE MAJOR RISK FACTORS FOR HEART ATTACK?

1. High Blood Pressure Yes _____ No _____
2. Elevated Cholesterol/Triglycerides Yes _____ No _____
3. Smoking Yes _____ No _____ If yes, number of years _____ Amount? _____
Quit Smoking _____
4. Diabetes Yes _____ No _____ Insulin Dependent Yes _____ No _____
5. Family History (father, mother, sister, or brother with heart attack before age 65) Yes _____ No _____
6. Any history of Drug Abuse? Yes _____ No _____

What is your Weight _____ Height _____

Exercise: Never _____ 1 - 2 times/wk. _____ 3 or more times/wk _____

Alcoholic beverages: Number/day _____ Number/wk _____

Caffeinated beverages: Number/day _____ Number/wk _____

Current Medications and Dosages:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you have any Allergies to medications? Yes _____ No _____ If yes, What medications and reaction: _____

List Hospitalizations below with year, reason, place, and physician.

1. _____
2. _____
3. _____
4. _____
5. _____

List any other current medical problems: _____

Signature _____