## Updated Medical History

**Patient Name**: _____ **Phone Number**: _____
**Height**: _____ **Weight**: _____ **DOB**: _____ **BMI**: _____
**Primary Care Physician**: _____

**List Medical Problems You Have or Had**:

_____
_____
_____

**List All Medications You Take**:

_____
_____
_____

**List Surgeries You Have Had**:

_____
_____
_____

**List Allergies to Medications**:

_____
_____
_____

**Do you have a latex allergy?** **YES** **NO**

**Can you Take Anti-Inflammatory Drugs (Ibuprofen, Aleve, Aspirin)?** **YES** **NO**

**List Any Medical Problems in Your Family**:

_____
_____

**What Hobbies Do You Have?** _____
**Do You Play Any Sports Regularly?** _____
**Do You Exercise?** _____

**What Pharmacy do you use?** _____

**Are you currently experiencing or have you experienced any of the following:**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Weight Loss or Gain | ☐ | ☐ | Asthma |
| ☐ | ☐ | Wound Healing Problems | ☐ | ☐ | Pneumonia |
| ☐ | ☐ | Psoriasis | ☐ | ☐ | Stomach Ulcers |
| ☐ | ☐ | Depression | ☐ | ☐ | Acid Reflux |
| ☐ | ☐ | Blood Clots | ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Bleeding Problems | ☐ | ☐ | Urinary Infections |
| ☐ | ☐ | Heart Attack | ☐ | ☐ | Fibromyalgia |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Gout |
| ☐ | ☐ | Stroke | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Sciatica | ☐ | ☐ | AIDS |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | Cancer | ☐ | ☐ | Taken Prednisone |
| ☐ | ☐ | Drink Alcohol | ☐ | ☐ | Use Recreational Drugs |
| ☐ | ☐ | Pneumonia Vaccine | ☐ | ☐ | Colon Screening (Colonoscopy) |
| ☐ | ☐ | Flu Vaccine | | | |

**Tobacco Use**: ☐ Never ☐Former ☐Occasional ☐ Everyday ☐ Light ☐Heavy

**Signature**: _____ **Date:** _____