Name: _____ **Date of Birth:** _____

Pharmacy: _____ **Referring Doctor:** _____

Reason for today's visit: _____

Height ____**ft** _____**in** **Weight**_____ **lbs** **Are you currently pregnant?** **Yes** _____ **No** _____

Are you right or left-handed? **Right** ____ **Left** ____

Medication Allergies: _____

CURRENT MEDICATION AND DOSES: Please list below.

PAST MEDICAL HISTORY: Please check any past conditions that apply:

Headache/Migraine	Heart Disease	Genitourinary Disease
Epilepsy/Seizures	Hypertension	Menstrual/Sexual Dysfunction
Stroke / TIA	Murmur	Venereal Disease
Head Injury	Thyroid Disease	Peptic Ulcer Disease
Dementia	Anemia	Congestive Heart Failure
Neuropathy	Cancer	Other Endocrine
Cervical Spine Disease	Diabetes	Mumps
Spinal Cord Injury	COPD	Arrhythmias
Lumbar Spine Disease	High Cholesterol	Polio
Other Neuromuscular	Asthma	Bleeding Disorder
Myocardial Infarction	Peripheral Vascular Disease	Measles
Depression	Liver Disease/Hepatitis	Allergy/Hay Fever
Mental Illness	Rheumatic Fever	Exposures
Arthritis	Pneumonia	Kidney Disease
Other:		

PAST SURGICAL HISTORY: Please list any past surgeries that you have had and the approximate dates.

_____

_____

_____