Name:	**Date of Birth:**	**Height:**	**Weight:**	**Shoe Size:**
Marital Status *(circle one)*: **Married Single**		**Pharmacy:**		
Primary Language:		**Race:**		
Who is your family doctor?		**Date Last Seen:** *(by your primary physician)*		
Emergency Contact Name:		**Emergency Contact #:**		

Employment *(check one)*: ☐ **Full-Time** ☐ **Part Time** ☐ **Student** ☐ **Unemployed** ☐ **Retired**

Email Address:

Have you had any of the following medical conditions in the past? *(if yes, please check)*

☐ **Alzheimer's**	☐ **Fibromyalgia**	☐ **Liver Problems**	☐ **Sciatica**
☐ **Anemia**	☐ **Gout**	☐ **Lung Problems**	☐ **Seizures**
☐ **Arthritis**	☐ **Hearing Problems**	☐ **Lyme's Disease**	☐ **Stomach Ulcers**
☐ **Asthma**	☐ **Heart Attacks**	☐ **Mitral Valve Prolapse**	☐ **Stroke**
☐ **Bleeding Disorders**	☐ **Heart Disease**	☐ **Nerve Disorders**	☐ **Thyroid Problems**
☐ **Cancer**	☐ **Hepatitis**	☐ **Osteoporosis**	☐ **Tuberculosis**
☐ **Depression**	☐ **High Blood Pressure**	☐ **Phlebitis**	☐ **Vascular Disease**
☐ **Diabetes**	☐ **Keloid/Scars**	☐ **Psychiatric Disorders**	☐ **NONE**
☐ **Eye Disorder**	☐ **Kidney Problems**	☐ **Rheumatic Fever**	☐ **Other** _____

Surgeries **Surgery/Date/Complication**	**Current Medications** **Medication/Dose**	**Medical Allergies** **Allergy/Reaction**

Do you have a history of smoking?
- ☐ No, never
- ☐ Yes, but I quit in/on _____
- ☐ Yes, I smoke ____ cigarettes/day
- ☐ Yes, I smoke cigars

Do you drink Alcoholic Beverages?
- ☐ No, Never
- ☐ Very Rare
- ☐ Occasionally/Socially
- ☐ Daily, ___ drinks/day

Do you use Illicit Drugs?
- ☐ No
- ☐ Yes

Family History
(check all that apply)

	Mother	**Father**
Living?		
Deceased?		
Age		
Arthritis:		
Blood clots:		
Cancer:		
Diabetes:		
Heart Attack:		
Hypertension:		
Keloid Former:		
Stroke:		
Other: (*please explain*)		

Have you experienced any of the following conditions recently? (*circle all that apply*)
- ☐ blurry vision
- ☐ headaches
- ☐ dizziness
- ☐ ringing in the ears
- ☐ fever
- ☐ dry mouth
- ☐ heart palpitations
- ☐ breathing difficulties
- ☐ stomach pain
- ☐ diarrhea
- ☐ constipation
- ☐ frequent urination
- ☐ muscle cramping
- ☐ rashes/skin problems

Please tell us about your complaint today: