PATIENT CURRENT MEDICAL HISTORY

Name: (Please Print Clearly)_____ Today's Date:_____

Please describe your main symptom(s) and how long you have had them:_____

_____

Do you have any specific health concerns or do you want specific health education / information: ( )Yes ( )No If so, please describe:_____

HABITS / DRUG USE:

Do you use tobacco now? ( )Yes ( )No Type and daily amount:_____How long?_____

Have you used tobacco in the past? ( )Yes ( )No Type and daily amount:_____How long?_____Stopped when?_____

Do you use alcoholic beverages? ( )Yes ( )No Type and daily amount:_____How long?_____Stopped when?_____

Do you use recreational drugs? ( )Yes ( )No Type and daily amount:_____How long?_____Stopped when?_____

Do relatives worry or complain about your drinking or drug use? ( )Yes ( )No

How much stress do you have daily? ( )A little ( )Some ( )A lot

Do you routinely use a seat belt? ( )Yes ( )No Are there firearms in the home? ( )Yes ( )No

Do you exercise regularly? ( )Yes ( )No

Are you exposed to toxic chemicals at work? ( )Yes ( )No If yes, type:_____

CURRRENT MEDICATION(S) (including vitamins and herbs):

Name of Drug	Dose	Frequency	Name of Drug	Dose	Frequency

DOCTOR'S NOTES:

_____

_____

_____

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Doctor's Signature:_____ **Date:**_____