REAL medicine+

NAME:_____ TODAY'S DATE:_____

DATE OF BIRTH:_____AGE: _____ OCCUPATION:_____

HOME STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____EMAIL:_____

REFERRAL:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____

PHONE:_____

DO YOU SMOKE? Y/N OR QUIT DETAILS:_____ DO

YOU DRINK ALCOHOL Y/N DETAILS:_____

DRUG USE: Y/N OR FORMER DETAILS:_____

ANY KNOWN DRUG ALLERGIES:_____

CURRENT MEDICAL CONDITIONS THAT YOU ARE BEING TREATED FOR:

CURRENT MEDICATIONS:

CURRENT SUPPLEMENTS:

REAL medicine+

SURGERIES: PLEASE LIST ANY WTH DATES & REASON

SCREENING HX: Last dermatology full skin exam?

MEDICAL ILLNESSES:

HIGH BLOOD PRESSURE	HEART BYPASS	HIGH CHOLESTEROL
HIGH BLOOD PRESSURE/ HYPERTENSION	HEART DISEASE	BLOOD CLOT
PULMONARY EMBOLISM	ARRHYTHMIA	LIVER DISEASE
HEPATITIS OR HIV	LUPUS OR OTHER AUTOIMMUNE DISEASE	
FIBROMYALGIA	DIABETES	THYROID DISEASE
ARTHRITIS	DEPRESSION	ANXIETY
PSYCHIATRIC DISORDER		
CANCER: TYPE/YEAR		

I HAVE FILLED OUT THIS FORM TO THE BEST OF MY KNOWLEDGE AND HAVE INCULDED ALL INFORMATION THAT HAS BEEN ASKED OF ME TRUTHFULLY. IF I HAVE FORGOTTEN TO INCLUDE ANY INFORMATION, I WILL LET MY PROVIDER KNOW AS THIS COMES TO MIND. I UNDERSTAND THAT ALL OF MY HISTORY IS NECESSARY TO BE TREATED APPROPRIATELY AND SAFELY.

PRINT NAME:_____DATE_____

SIGNATURE:_____