FULL NAME ______________________________

PHONE NUMBER ___________________________

ADDRESS _________________________________

EMAIL _____________________________________

____

DATE OF BIRTH ___________________________

DRIVERS LICENSE NUMBER ___________________________________

SOCIAL SECURITY NUMBER ___________________________________

SEX _______________________________________

HEIGHT ________ WEIGHT ________

☐ TOBACCO/NICOTINE HOW MUCH ___________ HOW LONG __________

☐ ALCOHOL HOW MUCH HOW LONG __________

☐ HISTORY OF DRUG ABUSE/USE TYPE/LAST USE _______________________

MEDICATION ALLERGIES ____

SURGERIES

☐ APPENDECTOMY

☐ BACK SURGERY

☐ EGD

☐ ORTHOPEDIC SURGERY

☐ CHOLECYSTECTOMY

☐ COLONOSCOPY

☐ OTHER ____

MEDICATIONS INCLUDING OVER THE COUNTER

NAME	DOSE	FREQUENCY

PAST MEDICAL HISTORY

- ☐ CANCER
- ☐ GLAUCOMA
- ☐ HIV/AIDS
- ☐ CACHEXIA (WASTING SYNDROME)
- ☐ ANOREXIA
- ☐ SEVERE CHRONIC PAIN
- ☐ SEVERE RECURRENT NAUSEA
- ☐ PERSISTENT MUSCLE SPASMS
- ☐ ULCERATIVE COLITIS
- ☐ FIBROMYALGIA
- ☐ PERIPHERAL NEUROPATHY
- ☐ SEIZURE DISORDER
- ☐ TERMINAL ILLNESS
- ☐ DIABETES MELLITUS
- ☐ KIDNEY DISEASE
- ☐ INSOMNIA
- ☐ SLEEP APNEA
- ☐ STROKE/TIA
- ☐ MIGRAINES
- ☐ SYNCOPE
- ☐ ARTHRITIS
- ☐ LUPUS
- ☐ PARKINSONS DISEASE
- ☐ SPINAL CORD DISEASE/INJURY
- ☐ CROHNS DISEASE
- ☐ INFLAMMATORY BOWEL DISEASE
- ☐ GASTRIC REFLUX DISEASE
- ☐ ALZHEIMERS DISEASE
- ☐ HYPERTENSION
- ☐ CORONARY ARTERY DISEASE
- ☐ ASTHMA
- ☐ COPD/BLACK LUNG
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PTSD
- ☐ BIPOLAR DISORDER
- ☐ TOURETTES SYNDROME
- ☐ THYROID DISEASE
- ☐ SICKLE CELL ANEMIA
- ☐ BLEEDING DISORDERS
- ☐ VISION ISSUES
- ☐ LEUKEMIA/LYMPHOMA
- ☐ SKIN DISEASES
- ☐ OTHER ____

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