The Clinic on Sixth – Patient Medical History Form

Date:_____

Name:_____ Height:_____ Weight:_____

Please fill out the following to help with your visit:

1. What problem brings you to our office?_____
2. **Preferred Pharmacy**:_____
3. **Primary Care Physician**:_____
4. Please check any health conditions that you have:

☐ High Blood Pressure	☐ Seizures	☐ Cancer of the :_____
☐ Diabetes	☐ Anxiety	
☐ Heart Disease	☐ Thyroid	
☐ Asthma	☐ Acid Reflux	
☐ Depression	☐ Arthritis	

5. Please list any other medical conditions that you have:_____
6. Please list any surgeries you have had:

☐ Ear Tubes	☐ Heart Bypass	☐ Hernia
☐ Thyroid	☐ Heart Stent	☐ Back
☐ Cataracts	☐ Tonsillectomy	☐ C-Section
☐ Appendix	☐ Sinus Surgery	☐ Tubal Ligation
☐ Gallbladder	☐ Breast Biopsy	☐ Hysterectomy

Others:_____

7. Please list all the medications / vitamins / herbal medicines you currently take:

8. List any medications that you are allergic to:

_____