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| **HEALTH HISTORY QUESTIONNAIRE** |

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| Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. PLEASE COMPLETE USING BLACK INK. |

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| Main reason for today's visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current Height and Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ALLERGIES** |

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| **List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.** |

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| ALLERGY |
| 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| REACTION |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **PHARMACY**LOCAL PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MAIL ORDER PHARMACY (IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MEDICATIONS****Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** |
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| DRUG NAME |
| 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| STRENGTH |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| FREQUENCY TAKEN |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**PAST SURGICAL HISTORY**

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| **SURGERY** |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **REASON** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **YEAR** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **HOSPITAL** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **IMMUNIZATION HISTORY** |

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| **Immunizations and most recent date:** |
|   Chickenpox | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Flu Shot | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Gardasil/HPV | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Hepatitis A | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Hepatitis B Meningococcus | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|   MMR *(Measles, Mumps, Rubella)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Pneumovax 23 *(penumonia)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Prevnar 13 *(pneumonia)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Tdap *(Tetanus and pertussis)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Tetanus | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Zostavax *(Shingles)* | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PAST MEDICAL HISTORY** |

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|  **Please circle ALL that apply:** |
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| Acne |
| ADD/ADHD |
| Allergic Rhinitis |
| Anxiety Disorder |
| Arthritis |
| Asthma |
| Bleeding Disorder |
| Blood Clots or (DVT) |
| Cancer |
| Chronic Back Pain |
| Chronic Pain |
| Claustrophobic |
| Clostridium Difficile (C.Diff) Colitis |
| Coronary Artery Disease |
| Depression |
| Diabetes - Insulin |
| Diabetes - Non-Insulin |

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| Dialysis |
| Diverticulitis/Diverticulosis |
| Fibromyalgia |
| Frequent Skin Sores |
| GERD (Acid Reflux Disorder) |
| Gout |
| Has Pacemaker |
| Heart Attack |
| Heart Murmur |
| Hemorrhoids |
| Hiatal Hernia or Reflux Disease |
| High Blood Pressure |
| High Cholesterol |
| History of Suicide Attempt  |
| HIV or AIDS |
| Joint Pain |
| Kidney Disease |

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| Kidney Stones |
| Leg/Foot Ulcers |
| Liver Disease |
| MRSA/Other Resistant bacterial Infections |
| Osteoporosis |
| Pancreatitis |
| Peripheral Edema/Swelling |
| Polio |
| PUD (Peptic Ulcer Disorder) |
| Pulmonary Embolism |
| Reflux or Ulcers |
| Stroke |
| Testicular Problem |
| Thyroid Disorders |
| Tuberculosis |
| Warts |

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|  **Please circle the condition that applies:**

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Headaches:* Headaches
* Migraines
* Tension
* Cluster

Endocrine Disorders:* Hypogonadism
* Adrenal Problems
* Other:

GYN Problems:* Endometriosis
* Fibroids
* Ovarian Cysts

Sleep Disorders:* Obstructive Sleep Apnea
* Insomnia
* Other:
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| Vision/Eye Disorders:* Glaucoma
* Low Visual Acuity
* Other

Intestinal Disorders: * IBS
* IBD (Crohns/Ulcerative Colitis)
* Other:

Sexually Transmitted Diseases:* Chlamydia
* Gonorrhea
* Genital Herpes
* Genital Warts
* Syphilis
* Other:
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| COPD:* Chronic Bronchitis
* Emphysema

Prostate Problems:* Benign Prostate
* Enlargement
* Prostate Cancer

Circulatory Issues:Venous InsufficiencyArterial Insufficiency |

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 Liver Disease: Hepatitis A Hepatitis B Hepatitis C |

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY** |

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| Have you EVER had an abnormal PAP or Mammogram? *Please specify and provide dates:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Last PAP Smear       Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Abnormal Y/N |
| Last Mammogram       Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Abnormal |
| Age of first menstrual period: \_\_\_\_\_\_\_\_ |
| Date of last menstrual period or age of menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of pregnancies: \_\_\_\_\_\_    Births: \_\_\_\_\_\_\_ |
| Miscarriages: \_\_\_\_\_\_       Abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cesarean sections: Y/N  If yes, then number: \_\_\_\_\_\_ |

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|   Bleeding between periods: Y/N |
|   Heavy periods: Y/N |
|   Extreme menstrual pain: Y/N |
|   Vaginal itching, burning, or discharge: Y/N |
|   Wake in the night to go to the bathroom: Y/N |
|   Hot flashes: Y/N |
|   Breast lump or nipple discharge: Y/N |
|   Painful intercourse: Y/N |
|   Sexually active: Y/N |
|         Current sexual partner is:    Female     Male |
|         Do you use condoms?    Yes     No |
|         Other Birth control method used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|          Interested in being screened for STDs: Y/N |

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| **FAMILY HEALTH HISTORY** |

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| **RELATION** | **ALIVE?** | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** |
| **Grandmother** (maternal) | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Grandfather**  (maternal) | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Grandmother** (paternal) | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Grandfather**  (paternal) | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Father** | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   |   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Mother** | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   |   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Brother/Sister** | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   |   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Brother/Sister** | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   |   |   Heart disease       Hypertension       Osteoporosis       Stroke |
| **Other:\_\_\_\_\_\_** | Y/N | \_\_\_\_\_\_ |   Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease |
|   |   |   |   Heart disease       Hypertension       Osteoporosis       Stroke |

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Please list any other Physicians or Medical Specialists that you currently use, as well as the medical issues they are managing for you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have ever had any of the following, please note the dates and results, if possible:

Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEXA/Bone Density Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note any test, with dates and results, you may have had in the past that you feel are currently relevant, including X-rays, MRI/A, CT, Ultrasounds, Nuclear medicine Scans, Biopsies, Endoscopy, Cystoscopy, Colposcopy, Stress Tests, Sleep Studies, Cardiac Catheterizations, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SOCIAL HISTORY** |

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| **Education**Less than 8th gradeHigh school2 year college       4 year collegePost graduate**Marital Status**MarriedSingleDivorcedSeparatedWidowedDomestic Partner |
| **Exercise Level**NoneOccasionalModerateHigh |

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| **Name:****DOB:** **Age:****Address:****Phone Number:****Insurance Provider & Member ID:**  |

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| **Caffeine** NoneOccasionalModerateHeavy# of cups/cans per day \_\_\_\_\_**Alcohol**Do you drink alcohol? Y/NIf so, how often?Occasionally< 3 times/week>3 times/weekDrinks per week \_\_\_\_ |  |
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|   | **Tobacco**Current smoker? Y/NCigarettes: \_\_\_\_ pks./dayChew: ­­­\_\_\_\_ /dayCigars: \_\_\_\_/day  # of years: \_\_\_\_\_\_ Former smoker? Y/N Year quit \_\_\_\_\_ |

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**Drugs**Do you use recreational or street drugs? Y/NIf yes, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Anyone currently using marijuana for any reason will not be accepted as a new patient.) Have you used recreational or street drugs in the past? Y/NIf yes, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**Occupation:**

**Religious Affiliation:**

**Interests/Hobbies:**

 **Do we see any other family members?**

**Name and ages of children, if any:**

**Please add any other information about your health that you would like your provider to know here:**

**Were you referred by someone? If so, whom can we thank for the referral?**

**Are you coming to Dr. Hippeard for controlled substances, such as Xanax, Ativan, Valium, Klonopin, Adderal, Ritalin, Concerta, Vyvanse, Hydrocodone, or Oxycodone? Please note that Dr. Hippeard will NOT prescribe these medications .**

**Are you coming to Dr. Hippeard for work related issues/concerns? Please describe.**

**Are you coming to Dr. Hippeard for concerns related to COVID or the COVID vaccination? Please note that Dr. Hippeard will NOT prescribe Ivermectin or issue medical documentation exempting you from employer requirements to take the COVID vaccine.**

**Are you currently under the care of any other providers or specialists? If yes, please provide their names and specialty.**

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Patient, Guardian, or Caregiver Signature Date