Reason for your visit(if it is a follow up, please detail what you are following up for):

Do you have any drug Allergies?(Fill out the table below)

Name of Drug	Severity of Allergy	Reaction During Allergy

What Medications do you take?:

Name of Medication	Dose	Frequency

What is your Medical History?

☐ No Significant Medical History	☐ Stroke	☐ Diabetes Type II	☐ Neuropathy
☐ Movement Disorder	☐ Kidney Disease	☐ Liver Disease	☐ Memory Loss
☐ Multiple Sclerosis	☐ Dyslipidemia	☐ Cancer	☐ Seizures
☐ Coronary Artery Disease	☐ High Blood Pressure		

What is your surgical history?

☐ None ☐ Tonsillectomy/Adenoidectomy ☐ Appendix ☐ Gallbladder

☐ Hysterectomy ☐ Prostate ☐ Cosmetic procedures

☐ Other:

What is your family history?(Please include which family member; e.g sister, brother, etc)

Family Med Hx	Family Member	Family Med Hx	Family Member	Fam Med Hx	Family Member
☐ No Significant Medical History		☐ Stroke		☐ Diabetes Type II	
☐ Movement Disorder		☐ Kidney Disease		☐ Liver Disease	
☐ Multiple Sclerosis		☐ Dyslipidemia		☐ Cancer	
☐ Neuropathy		☐ Seizures		☐ Coronary Artery Disease	
☐ Memory Loss		☐ Dementia		☐ High Blood Pressure	
☐ Other					

What is your social history?

Do you smoke? ☐ No ☐ Yes, and I might quit ☐ Yes, but I am not ready to quit

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational or other drugs? ☐ Yes ☐ No

How much caffeine drinks do you consume daily?

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Do you have Children? ☐ Yes ☐ No

Residence: ☐ House ☐ Apartment ☐ Skilled Nursing Facility

Are you Sexually Active: ☐ Yes ☐ No

Have you ever had a sexually transmitted disease: ☐ Yes ☐ No

What is your dominant hand?

☐ Right-Handed ☐ Left-Handed ☐ Ambidextrous