LEGACY
Health & Wellness

Other History

Patient Name: _____ **DOB:** _____ **Date:** _____

Surgical History/Hospitalizations

1. _____
2. _____
3. _____
4. _____

Allergies (food,medications,latex,environmental) _____

Medications (including OTC's, supplements, hormone therapies) _____

_____

_____

Family History

☐ Heart Disease ☐ Kidney Disease ☐ Blood Clots ☐ Aneurysm ☐ Cancer
☐ Diabetes ☐ Hypertension ☐ Varicose Veins ☐ High cholesterol ☐ Stroke/TIA
☐ Other: _____

Social History

1. What type of work do you do? _____ Schedule?_____
2. Who lives with you? _____

_____

3. Do you smoke? ☐ No, have you ever smoked? ☐ Yes ☐ No ☐ Yes, # per day: _____ How many years? _____
4. Do you drink alcohol? _____ If yes, how often and how much do you consume? _____
5. Do you use marijuana or other illegal substances? ☐ Yes ☐ No

Substance? _____ How often? _____
Substance? _____ How often? _____
Substance? _____ How often? _____

6. Check all that apply:

☐ I have completed my family
☐ I am married
☐ I am sexually active
☐ I want to be sexually active
☐ I have a history of using steroids for exercise performance

Please feel free to provide us with any other information you feel is pertinent to your medical history. The more information we have the better we are able to assist you with your symptoms.

_____

_____

_____

Please sign indicating all information provided is accurate and complete.

Patient Signature: _____ Date: _____