ASPEN CLINIC - MEDICAL HISTORY FORM

THIS IS A RECORD OF YOUR MEDICAL HISTORY AND WILL NOT BE RELEASED TO ANY PERSON UNLESS WE ARE AUTHORIZED TO DO SO.

NAME:_____AGE:_____

OCCUPATION_____

DATE OF LAST PHYSICAL EXAM: _____

ANY ABNORMAL RESULTS/FINDINGS? YES/NO IF YES PLEASE LIST_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)					
HIGH BLOOD PRESSURE	**YES**	**NO**	**ASTHMA**	**YES**	**NO**
HEART DISEASE/ATTACK	**YES**	**NO**	**CANCER**	**YES**	**NO**
DIABETES	**YES**	**NO**	**SLEEP APNEA**	**YES**	**NO**
THYROID DISEASE	**YES**	**NO**	**DEPRESSION**	**YES**	**NO**
GLAUCOMA	**YES**	**NO**	**BULIMIA/ANOREXIA**	**YES**	**NO**
MITRAL VALVE PROLAPSE	**YES**	**NO**	**STROKE**	**YES**	**NO**

LIST OTHER DIAGNOSIS/ILLNESS:

_____

PLEASE LIST ANY PAST AND IMPENDING SURGERIES AND DATES: _____

_____

_____

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN YOUR IMMEDIATE FAMILY?					
HEART DISEASE/ATTACK	YES	NO	STROKE	YES	NO
DIABETES	YES	NO	HIGH CHOLESTEROL	YES	NO
HIGH BLOOD PRESSURE	YES	NO	OBESITY	YES	NO

LIST ALL MEDICATIONS/VITAMINS/HERBAL REMEDIES & DOSES YOU ARE CURRENTLY TAKING:

_____

_____

DO YOU HAVE ALLERGIES TO ANY DRUGS/MEDICATIONS AND LIST REACTIONS: YES/NO PLEASE LIST:

_____

HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE? YES/NO

DO YOU DRINK ALCOHOL? YES/NO

IF YES HOW MUCH AND HOW OFTEN DO YOU DRINK? _____

DO YOU SMOKE? YES/NO

ARE YOU PREGNANT? YES/NO **ARE YOU NURSING? YES/NO**

*** I HEREBY ACKNOWLEDGE THAT ALL THE INFORMATION I HAVE LISTED IS TRUE:**

SIGNATURE: _____ **DATE: _____**