

Patient Medical History

Please print this form, fill it out, and either fax it or bring it with you for your visit. Thank you!



Name: _____

Date of Birth: / / Today's Date: / /
mo. date year mo. date year

Tempe Office

6301 S. McClintock Dr.,
Suite 215
Tempe, AZ 85283
Phone: (480) 820-6657
Fax: (480) 730-0803

Gilbert Office

2550 E. Guadalupe Rd.,
Suite 109
Gilbert, AZ 85234
Phone: (480) 505-4475
Fax: (480) 505-4252

Allergies to Medications

- None
 Yes Reaction: _____

Family History

Include parents, siblings and maternal or paternal grandparents only.

- Adopted, or no known family history
 No family history of heart disease, cancer, diabetes, infectious disease or osteoporosis

Cardiac Disease

- None Heart Disease List family member(s): _____
 Unknown Stroke List family member(s): _____
 Elevated Cholesterol List family member(s): _____
 Elevated Blood Pressure List family member(s): _____

Cancer

- None Yes List family member(s) and type: _____
 Unknown _____

Diabetes

- None Yes List family member(s) and type: _____
 Unknown _____

Infectious Diseases

- None HIV List family member(s): _____
 Unknown Hepatitis B List family member(s): _____
 Hepatitis C List family member(s): _____
 Tuberculosis List family member(s): _____

Osteoporosis / Osteopenia

- None Yes List family member(s) and type: _____
 Unknown _____

Blood Disorders

- None Clotting Disorders List family member(s): _____
 Unknown Hemophilia List family member(s): _____
 Sickle Cell Disease List family member(s): _____

Medications

Please list all medications you are taking (include over-the counter supplements i.e.: vitamins, calcium, or herbal remedies), frequency of usage, and dosage of medication (if known).
