OptiWell MD™

Patient Medical History

Date: _____

Patient Name _____ Date of Birth _____

Address _____ Sex _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Phone (_____) _____ Email _____

Employer/Occupation _____

Work Address _____

City _____ State _____ Zip _____

In Case of Emergency Contact _____

Contact Phone Number _____

Relationship To You _____

Health History

Have You Had or Do You Currently Have?

_____ High Blood Pressure
_____ Chest Pain/Angina
_____ Heart Attack(s)
_____ Irregular Heart Beat
_____ Cardiac Pacemaker
_____ Are you on Dialysis?
_____ Stomach Ulcers
_____ History of Breast Cancer
_____ History of Uterine Cancer
_____ History of Ovarian Cancer
_____ History of Prostate Cancer

_____ Low Sex Drive
_____ Blood Disorder Such as Anemia
_____ Bruise Easily
_____ Gallbladder Trouble
_____ Fainting Spells
_____ Thyroid Trouble
_____ Diabetes
_____ Low Blood Sugar
_____ Swollen Ankles, Arthritis, or Joint Disease
_____ Sleep Disorders
_____ Digestuve Disorders

Are You Currently Taking?

_____ Blood Thinners
_____ Sleep-Inducing Medications
_____ Cortisone
_____ Medications for Acid Reflux or GERD
_____ Thyroid Meds
_____ Antibiotics
_____ Prescription Appetite Suppressants (Adipex, phentermine, etc.)

_____ Blood pressure meds
_____ Aspirin
_____ Ibuprofen or Tylenol
_____ Antihistamines/Decongestants
_____ Muscle Relaxants or Tranquilizers
_____ Insulin or Diabetic Meds
_____ Antidepressants or Anxiety Medications

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Patient Medical History (2)

Are You Allergic To or Have You Had a Reaction To?

_____ Local Anesthetics _____ Penicillin _____ Codeine or other Narcotics

_____ Aspirin _____ Other Antibiotics _____ Latex

_____ Any other drug allergies? _____

WOMEN

Could you possibly be pregnant? _____ Date of your last menstrual period: _____

Are you currently on birth control? _____ Date of your last pap smear:_____

Number of Pregnancies? _____ Date of your last mammogram: _____

MEN

Date of your last prostate exam: _____ Date of your last PSA test: _____

BOTH

Current Height _____

Current Weight _____

Do you consider yourself in good health? _____ YES _____ NO

Any change in your health in the past year? _____ YES _____ NO

Are you under the care of a physician for a specific condition? _____ YES _____ NO

Have you ever had surgery or been hospitalized?

If so, please list dates and reason

_____

_____

Does an immediate family member have a history of cancer, diabetes or heart problems?

_____

_____

Current Meds/Supplements	Strength	Dose/Comments

I certify that I have read and understand the questions on this form. I acknowledge that I will have the opportunity to discuss my health history with my doctor. I will not hold my doctor or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I have received the appropriate Patient Informed Consents and give my permission for treatment.

_____

Signature Date