



Convenient. Compassionate. Confidential.

### iTherapyRX Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Marital Status:    Single        Married        Divorced        Widowed        Significant Other

Occupation \_\_\_\_\_

Use of alcohol: Never    Socially    Drinks Per Week \_\_\_\_\_

Use of street drugs: Never    Type/Frequency \_\_\_\_\_

Use of tobacco:        Never    Previously, but quit    Packs/Day \_\_\_\_\_

Do you use smokeless tobacco?    Yes        No

List any allergies and types of reaction: \_\_\_\_\_

Have you ever had surgery or been hospitalized?

No    Yes    If yes, please list the date(s) and reason(s) \_\_\_\_\_

Are you presently having problems with:					
	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Vision			Frequent Headaches		
Hearing			Menstrual Periods		
Heart Disease			Thyroid Disease		
Breathing			Bleeding from Bowels		
Digestion			Depression		
Urination			Dizziness, Fainting		
Arthritis			Sex Organs		
Rash or Itching			Other		
Diabetes					

(Check all that apply to yourself and/or a family member)

Diagnosis	Self	Family Member	Diagnosis	Self	Family Member
Heart Disease			Arthritis		
High Cholesterol			Osteoporosis		
High Blood Pressure			Asthma or COPD		
Stroke			Tuberculosis		
Seizures			Alcoholism		
Diabetes			Depression or Anxiety		
Kidney Disease			Cancer, if so what type?		
Glaucoma			Other		

Medications: What prescribed and non-prescribed medicine(s) do you take?

- |          |           |
|----------|-----------|
| 1) _____ | 6) _____  |
| 2) _____ | 7) _____  |
| 3) _____ | 8) _____  |
| 4) _____ | 9) _____  |
| 5) _____ | 10) _____ |