VITALITY HEALTH

Medical History Form

9240 Bonita Beach Rd
Suite 1114
Bonita Springs, FL 34135

Date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Primary Physician Name: _____ Phone: _____

List any Allergies: _____

_____

Social History:

Do you smoke? ☐ Yes ☐ No (if yes, how often per day) _____

Do you drink? ☐ Yes ☐ No (if yes, how often per week) _____

Do you exercise regularly? ☐ Yes ☐ No (if yes, how often per week) _____

Medical History:

List any NEW medical conditions that you currently have or have had in the past not listed on previous medical history form:

_____

_____

List any NEW hospitalizations/surgeries that you have had not listed on previous medical history form: _____

_____

_____

List ALL medications you are currently taking: _____

_____

List ALL Vitamin/Mineral Supplements (including OTC) you are taking: _____

_____

Family History (check all that apply):

☐ Stroke ☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes

☐ High Cholesterol ☐ Osteoporosis ☐ Anemia ☐ Thyroid Disease ☐ Cancer

☐ Other: (specify) _____

Patient Printed Name: _____

Patient Signature: _____ Date: _____

*Please email completed form to kurt@vitalityhealthsfl.com