ATLAS MEDICAL CONSULTANTS

Personal Health History Form

Which of the following are you currently being treated for or have been treated for in the past (check all that apply)

☐Heart Disease	☐Shortness of breath	☐Diabetes	☐High blood pressure
☐High cholesterol	☐Lung problems	☐Hepatitis/Liver problems	☐Stroke
☐Sinus problems	☐Arthritis	☐Neurological Problems	☐Thyroid disease

☐Cancer: Type:_____

Please list any current or past medical problems not listed above;

_____
_____
_____
_____
_____
_____

Have you ever been hospitalized; if so list date, hospital, and reason;

Date	Hospital	Reason

_____
_____
_____
_____
_____

Have you ever had surgery; if so please list date of surgery, what surgery, reason;

Date	Hospital	Reason

_____
_____
_____
_____

Are you currently taking any medications, prescribed or Over-the-counter, if so please list the medication, strength and how many times you take the medication;

Medication	Strength	How often

_____
_____
_____
_____
_____

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Do you have any allergies to medications; ☐Yes ☐No
Please list any allergy and reaction/side effect;

Medication Reaction

_____
_____
_____
_____
_____

Do you have any illness or disease in your family, if so please list below;

Disease/illness Relation

_____
_____
_____
_____
_____

Have you or do you currently smoke: ☐Cigarettes ☐Marijuana ☐Vape/e-cigarettes ☐Cigars
How often do you smoke: ☐Daily ☐Weekly ☐Socially
When did you start smoking:_____
When did you stop smoking:_____
Do you plan to quit smoking: ☐Yes ☐No
Do you need assistance to quit smoking: ☐Yes ☐No

Do you drink alcohol: ☐Yes ☐No
How often: ☐2-4 times a month ☐2-3 times a week ☐4 or more times a week

What is your employment status: ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Student

Please list all your current/past occupations:

_____
_____
_____
_____
_____

Any **pets/birds** in the home? If so, what kind and how many?

_____
_____
_____
_____
_____