

Tustin Longevity Center
 13422 Newport Avenue, Suite L
 Tustin, CA92780 Phone: 714-544-1521

Medical History Form

This information is confidential and will not be released without your written permission.
 Providing us with the following information will help us to better serve your medical needs.

Today's Date:			
PATIENT INFORMATION			
Last Name	First Name	Middle	Birth Date
Please list any concerns you have for your visit today			
Please list all prescription medications			
Medication Name	Strength/Dosage	How often do you take?	
Please list any allergies to food or medications			
Please list any non prescription medications you take or nutritional supplements (aspirin, Tylenol, vitamins, herbals, etc.)			
Product	Strength	How often to you take?	
FAMILY HISTORY			
Please list any major diseases that members of your family have or have had – including heart disease, Stroke, cancer (including the type), diabetes, high blood pressure, etc. If the family member is deceased, please list the cause and age of death.			
	Major Diseases	Cause Of Death	Age At Death
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Paternal Grandparents			
Maternal Grandparents			

PERSONAL HISTORY – Patient Name:		
Occupation	Marital Status	
	<input type="checkbox"/> Sgl <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid	
Do you Smoke? (pipe, cigar, etc.)	If currently smoking, how many per day?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	If not smoking, when did you quit?	
If you smoked, how much per day?		
If you drink alcohol, how much per day?		
Is there any previous use of cocaine or other addictives?		
Has there been any recent weight loss or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please describe your diet. High fat? Low carb? Vegan? Etc.		
List any toxic chemicals you may have been exposed to.		
List any foreign countries you visited last year		

Immunizations and History

Immunization	Year	Immunization	Year

Do you have or have you ever had any of the following:

Alcoholism	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> Yes	Hernia	<input type="checkbox"/> Yes
Angina	<input type="checkbox"/> Yes	Hiatal Hernia	<input type="checkbox"/> Yes
Anxiety or Panic Disorder	<input type="checkbox"/> Yes	High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes
Arrhythmia	<input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> Yes	Hives, Eczema or Hay Fever	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	Joint or Kidney Disease	<input type="checkbox"/> Yes
Back Pain/Injury	<input type="checkbox"/> Yes	Liver Disease	<input type="checkbox"/> Yes
Bleeding Disorders	<input type="checkbox"/> Yes	Migraines	<input type="checkbox"/> Yes
Bone Abnormalities	<input type="checkbox"/> Yes	Mononucleosis	<input type="checkbox"/> Yes
Bronchitis	<input type="checkbox"/> Yes	Pneumonia	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes	Prostate Problems	<input type="checkbox"/> Yes
Congestive Heart Failure	<input type="checkbox"/> Yes	Psychiatric Disorders	<input type="checkbox"/> Yes
Coronary Artery Disease	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> Yes	Substance Abuse	<input type="checkbox"/> Yes
Diverticulitis/Diverticulosis	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> Yes
Emphysema/COPD	<input type="checkbox"/> Yes	Ulcers	<input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> Yes	Urine/Bladder Infections	<input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> Yes	Urinary Tract Problems	<input type="checkbox"/> Yes
Hemorrhoids	<input type="checkbox"/> Yes	Venereal Disease	<input type="checkbox"/> Yes
Other			

HOSPITALIZATIONS, OPERATIONS AND PROCEDURES

YEAR	REASON

Name:	Date
X	
PATIENT/GUARDIAN SIGNATURE	