DR. JAMES WEBB & ASSOCIATES

Patient Name:____DOB:____________

DRUG ALLERGIES: (Please circle)

Penicillin	Sulfa Drugs	Morphine	Ibuprofen	Tylenol	Fentanyl	Hydrocodone
Propofol	Versed	Barbituates	IV Contrast	Other:______________________________		

Do you use marijuana? YES NO Do you have a medical marijuana card? YES NO

Medication List

Name of Medication / Dosage / Frequency	Name of Medication / Dosage / Frequency

Have you taken any of the following medications?

Blood Thinner(s) YES NO Steroids (cortisone, prednisone) YES NO

Antidepressants YES NO Proton Pump Inhibitor (Nexium, Prilosec) YES NO

Hormone Replacement Therapy (Estrogen / Testosterone) YES NO

DO YOU HAVE OR HAVE YOU HAD:

Vertebral Fracture	YES	NO	Broken Bone as adult	YES	NO	GERD / Heartburn	YES	NO
Crohn's Disease	YES	NO	Ulcerative Colitis	YES	NO	Celiac Disease	YES	NO
Osteoporosis	YES	NO	Hip Fracture	YES	NO	Diabetes	YES	NO
HyperThyroid	YES	NO	HypoThyroid	YES	NO	Gastric Bypass Surgery	YES	NO
Heart Disease	YES	NO	Heart Attack	YES	NO	Bypass/Stents	YES	NO
Stroke	YES	NO	Aneurysm	YES	NO	Alzheimer's	YES	NO
Kidney Disease	YES	NO	Hypertension	YES	NO	Cancer	YES	NO
Mental Disorder	YES	NO	Alcoholism	YES	NO	Drug Abuse	YES	NO
Migraines	YES	NO	Fall from Height	YES	NO			

Other Current Health Problems:

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SURGERIES

Year	**Reason**	**Hospital Name**

Do you smoke/chew tobacco/vape?	YES	NO	if so, how much/often?______________________
Do you drink alcohol?	YES	NO	if so, how much/often?______________________
Do you use drugs?	YES	NO	if so, how much/often?______________________
Do you exercise regularly?	YES	NO	if so, how much/often?______________________
Sexually Active?	YES	NO	Birth Control Method? ______________________

Dr. James Webb & Associates

Patient Name:____DOB:__________

Family History

	Living	Deceased	If deceased, please list cause:
Father	☐	☐	______________________________
Mother	☐	☐	______________________________
Siblings	☐	☐	______________________________
	☐	☐	______________________________
Children	☐	☐	______________________________
	☐	☐	______________________________

Any Family history of:	Yes	No	Who?		Yes	No	Who?
Heart Disease	☐	☐	__________	Stroke	☐	☐	__________
Hypertension	☐	☐	__________	Cancer	☐	☐	__________
Diabetes	☐	☐	__________	Alcoholism	☐	☐	__________
Mental Disorder	☐	☐	__________	Hip Fracture	☐	☐	__________
Thyroid Disorder	☐	☐	__________	Osteoporosis	☐	☐	__________
Kidney Disease	☐	☐	__________	IBD/IBS	☐	☐	__________

For Women Only:

Last Menstrual Period__________ Date of Last Mammogram:__________ Age at Menopause__________

Hysterectomy? YES NO Do you have your ovaries? YES NO Date of Hysterectomy:________

For Males Only:

History of Low Testosterone: YES NO Have you taken Testosterone before: YES NO

Prostate Issues: YES NO