PBPM™ *Progressive Medicine*

# Annual Medical History Form

**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) _____

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Patient Printed Name: _____

Patient Signature: _____ Date: _____

***Please fax completed form to (561) 296-9215***

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