Performance Medicine Institute
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General Medical History

Name	Gender	Date of Birth	Race/Ethnicity	
Street Address		City	State	Zip

Mobile Phone	Home Phone	E-Mail Address
Primary Care Physician Name and Phone Number	Referring Physician Name and Phone Number	
Parent/Guardian/Caregiver	Emergency Contact Name	Emergency Contact Phone
Primary Insurance Company	Responsible Party/Insured	Policy Number
Secondary Insurance Company	Responsible Party/Insured	Policy Number
Marital Status ☐Single ☐Married ☐Divorced ☐Widowed	Occupation	Medication/Substance Allergies
Do You Use Tobacco? ☐No ☐Yes Packs/Day _____	Do You Drink Alcohol? ☐No ☐Yes Drinks/Week _____	Do You Take Recreational Drugs? ☐No ☐Yes _____

List All Medications, Vitamins and Supplements You Are Taking

Circle All Medical Conditions You Have/Had

Adrenal Disorders Anemia Anxiety Asthma Autoimmune Disease Back/Neck Pain
Blood Disorders Cancer/Tumor Chronic Infection COPD COVID-19 Depression
Digestive Disorder Eating Disorder Epilepsy/Seizures Foot Ulcer Fracture Gout
Head Injury/Concussion Headaches/Migraines Heart Disease High Blood Pressure
High Cholesterol HIV/AIDS Hyperthyroid Disease Hypothyroid Disease Incontinence
Joint Pain/Injury Joint Replacement Kidney Disease Liver Disease Lung Disease
Menstrual Disorders Neurological Disorders Obesity Osteoporosis Osteoarthritis Pancreatitis
PCOS Pituitary Disorders Sleep Apnea Stomach Ulcers/Reflux Stroke Type 1 Diabetes
Type 2 Diabetes Vascular Disease

List Any Other Condition You Think We Should Know About

List Any Previous Surgeries You've Had And The Approximate Dates