Medical History

Ki Hassler D.O., F.A.C.C.
1215 Jacaranda Blvd
Venice, FL 34292
Phone: 941-451-8282
Fax: 877-652-3059

Date_____ Full Name_____

Reason for Appointment _____

Primary Care Physician_____

List medications including milligrams and how often you take them (include Aspirin and all vitamins)

_____
_____
_____
_____
_____

List any medication allergies and reactions

_____
_____
_____
_____
_____

List all operations and approximate year

_____
_____
_____
_____
_____

List hospitalizations and approximate year

_____
_____
_____
_____
_____

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Social History

How often do you exercise? _____

Type of exercise_____

Marital Status _____ Seasonal Resident: Yes No

How often do you drink alcohol? _____

Type of Alcohol _____

How often do you drink caffeine? _____

Smoking Status:

☐ Current Type_____ Amount/Frequency_____

☐ Former Approx. quit date _____

☐ Never

Family History *(Check appropriate boxes)*

	None	Mother	Father	Sister	Brother	Daughter	Son
Diabetes							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Stroke							

This office will send prescriptions and records electronically to the pharmacies, facilities, and doctors you designate. Do you consent to this electronic exchange of information? ☐ Yes ☐ No

Signature_____