

Health History

Please fill out as much as you can in this form, and please take your time to fill it out carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential.

Name:	_____	Date:	_____
Address:	_____		
City:	_____	State:	_____
		Zip:	_____
Phone	home: _____	mobile:	_____
Email:	_____		
Date of Birth:	_____	Age:	_____
		Gender:	_____
		Marital Status:	_____
Occupation:	_____		

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs,...)

Medications (names and dosages) Please attach an additional page if necessary.

Vitamins / Supplements / Herbs

Exercise

Days per week

Length of workout

Type of activity

Diet

Meals

Snacks

Caffeinated

drinks

Alcohol

per week

Personal History

Please check any conditions or symptoms you have now.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> liver/gall bladder disease | <input type="checkbox"/> stroke | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> hypo / hyperglycemia | <input type="checkbox"/> kidney disease | <input type="checkbox"/> elevated blood cholesterol |
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> food allergies/intolerance | <input type="checkbox"/> diverticulitis / IBS |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> seizures | <input type="checkbox"/> hepatitis | <input type="checkbox"/> Raynaud's disease |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> anemia | <input type="checkbox"/> thyroid imbalance | <input type="checkbox"/> respiratory allergies |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> lyme disease | <input type="checkbox"/> chronic pain condition | <input type="checkbox"/> impotence |
| <input type="checkbox"/> gastritis / pancreatitis | <input type="checkbox"/> asthma | <input type="checkbox"/> infertility | <input type="checkbox"/> emphysema |

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> diabetes _____ | <input type="checkbox"/> seizures _____ | <input type="checkbox"/> heart disease _____ | <input type="checkbox"/> stroke _____ |
| <input type="checkbox"/> high blood pressure _____ | <input type="checkbox"/> allergies _____ | <input type="checkbox"/> cancer _____ | <input type="checkbox"/> asthma _____ |
| <input type="checkbox"/> other _____ | | | |

Main complaint (symptoms, diagnosis, duration,...)
