

Patient Health History Form

What health concerns would you like to discuss today? _____

Food or Drug Allergies/Reaction None

Do you smoke? Yes NO

Have you ever smoked? Yes NO

If yes, how much? _____

For how long? _____

Do you drink alcohol, beer? Yes NO

If yes, how much? _____

HEALTH PROBLEMS YOU HAVE: None

Check all that apply -

- High blood pressure
 - Diabetes
 - Arthritis
 - Heart failure
 - Heart attack
 - Asthma or lung disease
 - Cancer, where
 - Stroke
 - Thyroid problem -
Hypothyroid/hyperthyroid
 - High Cholesterol
 - Hepatitis (liver disease)
 - Seizures (epilepsy)
 - Blood clots
 - Anemia or sickle cell disease
 - Depression
 - Bipolar
 - Anxiety
 - Kidney Disease
 - Glaucoma/eye problem
 - Skin problem/psoriasis/dermatitis
- Other: _____

Name: _____

DOB: _____ AGE: _____

Address: _____

City: _____ State: _____ Zip: _____

CellPhone: _____

Email: _____

Occupation: _____

Emergency Contact: _____

Phone: _____

Who Referred you? _____

SURGERIES YOU HAVE HAD: None

Check all that apply -

- Hysterectomy
- Ovaries removed
- Tubal ligation
- C-Section delivery
- Knee replacement
- Hip replacement
- Pacemaker inserted
- Heart bypass surgery
- Heart valve surgery
- Gallbladder removed
- Appendix removed
- Hernia repaired
- Prostate surgery
- Tonsils removed
- Cataracts removed
- Foot surgery, Bunion, hammertoe

Other: _____

FAMILY HISTORY:

- Heart Disease Stroke
- High Blood Pressure
- Diabetes
- Uterine/Ovarian Cancer
- Breast Cancer Colon Cancer
- Prostate Cancer

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MEDICINES YOU TAKE THAT ARE PRESCRIBED BY A DOCTOR: None

Drug Name	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER MEDICATIONS YOU TAKE:

- Aspirin 81mg
- Aspirin 325mg
- Tylenol
- Advil/Motrin/Aleve
- Allegra, Claritin, Zyrtec, Benadryl
- Sudafed
- Cold or cough syrups
- Diet pills
- Tums, Rolaids, or antacids
- Other: _____

VITAMINS, MINERALS, SUPPLEMENTS

- None
- Vitamin D
- Multivitamin
- Calcium
- Iron
- St John's Wort
- Ashwagandha
- Glucosamine
- Magnesium
- _____

DIETARY HABITS: I commonly consume -

- Coffee
- Regular Soda
- Minimize Carbs
- Lowfat
- Avoid Dairy/Cheese
- Chips/Crackers
- Eat Snacks After Dinner/Before Bed
- Diet Soda
- High Protein
- Vegetarian/Vegan
- Candy/Chocolate

EXERCISE HABITS:

- I exercise _____hrs/week
- Lift weights
 - Aerobic (jog/walk/run/hike)
 - Swim
 - Pilates/Yoga
 - Other

STRESS LEVEL:

- I am often sad and blue
- I am under a lot of stress
- I overeat when stressed
- I have difficulty dealing with stress
- I practice meditation/relaxation techniques
- I have a good support system