Glow Health
MEDICAL CLINIC

Patient History Form

PATIENT INFORMATION						
	Last Name MI	*First*		*Female ( ) Male ( )*	*Birth Date*	*Age*
	Address	*Apt#*	*City*	*State*		*Zip*
	Home Phone	*Cell Phone*		*Work Number*		
	E-Mail			*Marital Status*	*Employer*	
	Height	*Weight*		*Goal Weight?*		
	Emergency Contact	*Relationship*			*Phone*	
	Physician	*Address*			*Phone*	
	Who Referred You?	*Name*				

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concerns and symptoms brings you to the clinic?

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What would you most like to achieve with this health consultation?

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Are you currently under the care of a physician/health professional for a medical/health condition?

❍ Yes ❍ No

If yes, please list: Include Physicians Name(s)

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Patient Name: ________________________________Date of Birth:________________

**Please check any medical conditions or health problems that you currently have or have had in the past?

Past Medical History			
Artificial joint/implant	❍ yes ❍ no	Kidney disease	❍ yes ❍ no
Asthma	❍ yes ❍ no	Lung/breathing issues	❍ yes ❍ no
Back Pain or Sciatica	❍ yes ❍ no	Mood Disorder	❍ yes ❍ no
Bleeding disorder	❍ yes ❍ no	Muscle or Joint Pain	❍ yes ❍ no
Blood Clotting problem	❍ yes ❍ no	Neck pain	❍ yes ❍ no
Cancer	❍ yes ❍ no	Osteoarthritis	❍ yes ❍ no
Carpal Tunnel Syndrome	❍ yes ❍ no	Osteoporosis/ Osteopenia	❍ yes ❍ no
Chest Pain	❍ yes ❍ no	Prostate problems	❍ yes ❍ no
Chronic bronchitis	❍ yes ❍ no	Psoriasis or eczema	❍ yes ❍ no
Chronic Indigestion	❍ yes ❍ no	Recurrent sinus infection	❍ yes ❍ no
Chronic pain problems	❍ yes ❍ no	Reproductive problem	❍ yes ❍ no
Constipation/diarrhea	❍ yes ❍ no	Rheumatoid Arthritis	❍ yes ❍ no
Diabetes	❍ yes ❍ no	Seasonal allergies	❍ yes ❍ no
Eye Problem - Glaucoma	❍ yes ❍ no	Seizures Disorder	❍ yes ❍ no
Fibromyalgia	❍ yes ❍ no	Shoulder problems	❍ yes ❍ no
Headache/Migraine	❍ yes ❍ no	Skin problems/dermatitis	❍ yes ❍ no
Heart Disease	❍ yes ❍ no	Stomach Ulcers	❍ yes ❍ no
Hepatitis/Liver disease	❍ yes ❍ no	Stroke/vascular disease	❍ yes ❍ no
Herniated Disc	❍ yes ❍ no	Tendonitis	❍ yes ❍ no
High Blood Pressure	❍ yes ❍ no	Thyroid disease	❍ yes ❍ no
Intestinal Disease	❍ yes ❍ no	Toenail Fungus	❍ yes ❍ no
Irregular Heart Beat	❍ yes ❍ no	Trigger points	❍ yes ❍ no

List any additional health problems not listed above:

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____

Patient Name: ________________________________ Date of Birth:________________

List any surgeries/operations you have had and when:

____

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____

Patient Name: ________________________________ Date of Birth: ________________

List any prescribed medications you are currently taking (or have taken in the recent past)

Medication Name	Date Started	Date Stopped	Dosage (# daily)

(If any additional medications please attach a separate page with the above info)

Nutritional supplements, vitamins, herbs, homeopathic remedies taken:

____

____

____

____

Have you ever used Hormone Replacement Therapy or Anabolic Steroids? ❍ yes ❍ no

Medication Allergies:

____

____

Environmental/Food Allergies:

____

____

Preventive Tests:	Date of last test known)	Results (if
Cholesterol	________________	________________
Blood Sugar	________________	________________
Bone density	________________	________________
Colonoscopy	________________	________________
Exercise stress test	________________	________________

Patient Name: ________________________________ Date of Birth: ________________

Family History (Write the relationship of the relative(s) with the disease on the adjacent lines)

Heart Disease	❍ yes ❍ no	____________________
High Blood Pressure	❍ yes ❍ no	____________________
Diabetes	❍ yes ❍ no	____________________
Arthritis	❍ yes ❍ no	____________________
Skin disorders	❍ yes ❍ no	____________________
Breast Cancer	❍ yes ❍ no	____________________
Uterine/Ovarian Cancer	❍ yes ❍ no	____________________
Prostate Cancer	❍ yes ❍ no	____________________
Colon Cancer	❍ yes ❍ no	____________________
Other Cancer	❍ yes ❍ no	____________________

List any other disease/condition in the family and relationship

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Women Only

ARE YOU PREGNANT? ❍ yes ❍ no

First day of last menstrual cycle ____________________________________

Date of last pap/pelvic/breast exam ______________ Results: ❍ normal ❍ abnormal

Date of last mammogram ____________________ Results: ❍ normal ❍ abnormal

Are you currently taking or have you in the past taken hormones or oral contraceptives?
❍ yes ❍ no

If yes, please list all hormones and oral contraceptives you have taken and when

____

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____

Patient Name: _______________________________Date of Birth:________________

Have you ever had any problems or concerns about taking hormone replacement therapy?

❍ yes ❍ no If

yes list problems.____ How many pregnancies have you had?______________ How many children?_________

Have you had a hysterectomy? ❍ yes ❍ no

If yes, were your ovaries removed? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

Have you had any menstrual irregularities? ❍ yes ❍ no

(if yes explain)

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____

Men Only

Date of last prostate exam: _______________

Are you concerned with loss of muscle mass, tone, or strength? ❍ yes ❍ no

Have you had problems with urination (decreased stream, frequent night urination) ❍ yes ❍ no

Do you perform periodic testicular self-examination? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

Patient Name: ________________________________ Date of Birth: ________________

Social History and Personal Health Habits

General **(Check all that apply)**

My Health is	Excellent	Good	Fair	Poor
My Physical fitness is	Excellent	Good	Fair	poor

Stress level:

I am often sad and blue	I have difficulty dealing with stress
I am under a lot of stress	I am fatigued all the time
I practice meditation/relation techniques	

Dietary Habits I commonly consume (check all that apply):

Coffee	Regular soft drinks	Diet soft drinks
Minimize carbs	Avoid red meat	Minimize fat
Vegetarian	I try to eat healthy	No special diet habit
Emphasize fruits, grains, vegetables	Chips/crackers	Candy/chocolate
I do not eat diary/cheese	High protein diet	

Exercise Habits:

NO special exercise habits	I routinely exercise _____hrs/week
Lift weights	Aerobic exercise (jog/walk/treadmill)
Swim	Stretch/yoga/Tai Chi/Other

Tobacco Use:

I never smoked cigarettes or chewed tobacco	I smoked _____packs/day for _____years
I smoke cigars/pipes/ecig	I quit smoking _____(mo/years_
I use recreational drugs ___________type	

Alcohol Use:

I never drink alcohol	I drink occasionally or socially	I drink 1 -2 drinks per day
I drink >2 drinks per day	I drink >4 drinks per day	

Patient Name: _______________________________Date of Birth:________________

List routine hobbies/sports/recreational activities

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