Glow Health
MEDICAL CLINIC

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:________________________

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
- ○ Multivitamin
- ○ Iron
- ○ Ashwagandha
- ○ Magnesium
- ○ Vitamin D
- ○ Calcium
- ○ St John's Wort
- ○ Glucosamine
- ○ ______________

DIETARY HABITS: I commonly consume -

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

EXERCISE HABITS:

I exercise ________hrs/week

- ○ Lift weights
- ○ Aerobic (jog/walk/run)
- ○ 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