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Name_____ **Date of Birth**_____ **Date**_____

Have you ever experienced any of the following? Explain any Yes responses.

Respiratory	**Yes**	**No**
Asthma		
Chronic Bronchitis		
COPD		
Pulmonary Hypertension		
Chronic Sinusitis		
Pneumonia		
Sleep Apnea		
Tuberculosis		

Cardiovascular	**Yes**	**No**
High Blood Pressure		
Low Blood Pressure		
Blood Clots		
Hemophilia		
Factor V Leiden		
Coronary Artery Disease		
Heart Attack		
Congestive Heart Failure		
Coronary Artery Blockage		
Carotid Artery Stenosis		
Arrhythmia		
High Cholesterol/High Triglycerides		

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Have you ever experienced any of the following? Explain any Yes responses.

Gastrointestinal	**Yes**	**No**
Reflux/Heartburn		
Stomach Ulcers		
GallBladder Disease		
Liver Disease		
Inflammatory Bowel Disease		
Crohn's Disease		
Ulcerative Colitis		
Celiac Disease		

Endocrine	**Yes**	**No**
Elevated Blood Sugar		
Diabetes (onset youth, insulin)		
Diabetes (onset adult, diet)		
Diabetes (onset adult, meds)		
Obesity		
Overweight		
Underweight		
Anorexia		
Bulimia		
Low Thyroid (hypothyroidism)		
Hashimoto's Thyroiditis		
High Thyroid (hyperthyroidism)		
Thyroid Nodules/Goiter		
Graves Disease		

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Have you ever experienced any of the following? Explain any Yes responses.

Neurological/Mental	**Yes**	**No**
Stroke		
Migraines		
Seizures		
ADD/ADHD		
Brain Injury/Concussion		
Depression		
History of Suicide Attempts		
Anger Management Problems		
Bipolar Disorder		
Post-Traumatic Stress Disorder		

Musculoskeletal	**Yes**	**No**
Arthritis		
Rheumatoid Arthritis		
Gout		
Osteopenia (weakening bones)		
Osteoporosis (weak bones)		

Immune System	**Yes**	**No**
HIV		
Hepatitis		
Herpes		
Mononucleosis/EBV		
Multiple Sclerosis/Lupus		

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Have you ever experienced any of the following? Explain any Yes responses.

Energy	**Yes**	**No**
Chronic Fatigue Syndrome		
Fibromyalgia		

Cancer History	**Yes**	**No**
Breast		
Uterine		
Cervical		
Colon		
Ovarian		
Skin		
Lung		
Bladder		
Kidney		
Thyroid		
Pancreatic		
Lymphoma		
Leukemia		
Other		

Skin	**Yes**	**No**
Eczema/Psoriasis		
Hives		
Athlete's Foot		
Acne/Vitiligo		

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Name_____ **Date of Birth**_____ **Date**_____

Have you ever experienced any of the following? Explain any Yes responses.

Gynecological/Obstetric History	**Yes**	**No**
Ovarian Cysts		
Endometriosis		
Uterine Fibroids		
Polycystic Ovarian Syndrome (PCOS)		
Fibrocystic Breast Disease		
PMS		
Have you ever used Birth Control Pills?		
Have you stopped having periods?		
When was your last period?	mm/dd/year ___/___/_____	
Family history of infertility?		
Have you ever had PPD?		
Have you ever Gestational Diabetes?		
How many times have you been pregnant?	#	How many births? _____
How many of your children are living?	#	Your children's ages? _____ _____ _____ _____
Are any of your children deceased?	When	How

Names and birthdates of your children

*Primary Care Physician: Name_____ *Specialist: Name_____

Phone Number_____ Phone Number_____

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Name_____ **Date of Birth**_____ **Date**_____

Prescription Medication

Name	Strength	Unit	How Many	How Often/When

Vitamins and Supplements/Over the Counter Medications

Name	Strength	Unit	How Many	How Often/When

Do you have any drug allergies? _____

Preferred Pharmacy

Name_____ **Phone**_____

Address_____

City_____ **State**_____ **Zip**_____

Fax_____ **Special Instructions**_____

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Name_____ **Date of Birth**_____ **Date**_____

Please describe your reason for today's visit

Briefly describe your top three health goals

Physical Dimensions

Current Height ____feet ____inches **Current Weight** _____pounds **Ideal Weight**_____pounds

Frame XS S M L XL XXL **Body Type** Masculine Feminine Androgynous

Nutrition Please explain any Yes responses.

Do you...	**Yes**	**No**
...drink fewer than 8 glasses of water a day?		
...use caffeine (coffee, tea, soda, energy drinks, etc…)?		
...take antacids frequently?		
...take lactose intolerance pills frequently?		
...regularly use acid-blocking drugs (Zantac, Prilosec)?		

Environmental/Food Allergies Please explain any Yes responses.

Do you have any environmental allergies?	**Yes**	**No**
Aerosol (cologne, smoke, cleaning fluids), Latex (gloves, tape)		
Seasonal (ragweed, pollen, dust), Pet/Animal (dog, cat, etc…)		
Do you have any food allergies	**Yes**	**No**
Grain (corn, wheat, rye, barley, spelt, etc…), Gluten, Soy, Yeast		
Dairy/Lactose, Eggs		
Nuts (peanuts, brazil nuts, walnuts, etc…)		
Shellfish (shrimp, lobster, crab)		

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Name_____ **Date of Birth**_____ **Date**_____

Sleep Please explain all Yes responses.

Sleep Problems	**Yes**	**No**
Do you snore or stop breathing while asleep? Do you use a sleep apnea device?		
Do you wake with a headache and/or feeling tired/not rested?		
Do you have trouble falling asleep?		
Do you wake up often throughout the night?		
Do you have trouble falling back to sleep after waking during the night?		
Do you take over-the-counter or prescription medication to sleep?		
Do you ever wake choking, gasping for air, or feeling smothered?		
Do you experience restlessness, tingling, or crawling in your arms or legs?		
As an adult, have you had episodes of talking or walking in your sleep?		
Does your heart pound at night?		
Average hours slept each night?	hours	

Stressors and Stress Management Please explain any Yes responses.

Stressors	**Yes**	**No**
Does your family cause you stress? (spouse, children)		
Do financial concerns cause you stress?		
Does your job cause you stress?		
Do you feel you have an excessive amount of stress in your life?		
Do you handle stress poorly?		
Have you ever been abused, a victim of a crime, or had a significant trauma?		
Have you experienced major losses in your life?		
Stress Management	**Yes**	**No**
Do you pray or meditate?		
Do you exercise?		
Do you get enough sleep?		

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Name_____ **Date of Birth**_____ **Date**_____

Social History

Occupation Status _____ **Occupation** _____

Sexual Orientation Heterosexual Homosexual Bisexual Other

Are you sexually active? Yes No **Marital Status** Married Single Divorced Widowed

Do you…
Use tobacco Yes No **Use Alcohol** Yes No **Use Street Drugs** Yes No

Tests and Procedures

Test or Procedure	Yes	No	Date	Result
Have you ever had a bone density/scan?				
Have you ever had a mammogram?				
Have you ever had a breast exam using thermography?				
Have you ever had a colonoscopy?				
Have you ever had a skin exam?				
Have you ever had a cardiac stress test?				
Have you ever had a calcium artery ultrasound?				
Have you ever been tested for glaucoma?				
Have you ever had a uterine ultrasound?				
Have you ever had a pap smear?				

Surgeries and Hospitalizations

List any surgeries or hospital stays	Dates	Where	Outcome

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Biological Family History

Family Member	Living	Deceased	Unknown	Age at Death	Cause of Death
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Family Medical History

Ailment	None	Unsure	Mother	Father	Brother	Sister	GM	GF	Aunt	Uncle
Breast Cancer										
Ovarian Cancer										
Uterine Cancer										
Prostate Cancer										
Colon Cancer										
Heart Attack										
Heart Disease										
High Cholesterol										
High Blood Pressure										
Diabetes										
Stroke										
Obesity										
Thyroid Disease										
Kidney Disease										