

WELCOME

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1 PATIENT INFORMATION

Date _____

Name _____

Address _____

City State Zip _____

Age _____ Birthdate _____

Occupation _____

Primary physician _____

Physician phone number _____

Whom can I thank for referring you? _____

2 CONTACT INFORMATION

Home phone _____

Work phone _____

Email _____

Best time and place to reach you _____

In case of emergency, contact:

Name _____

Relationship _____

Home phone _____

Work phone _____

3 MEDICATIONS / HISTORY

List medications or food supplements you are taking.

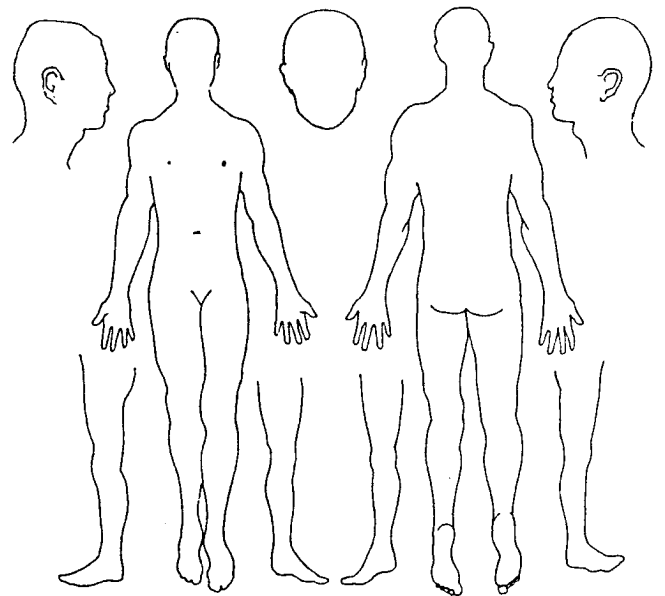
List serious illnesses, accidents or surgeries.

Check illnesses that have occurred in blood relatives.

- Diabetes High blood pressure Stroke
 Cancer Heart disease Kidney disease

4

Please indicate painful or distressed areas if any.



Comments:

5

HEALTH HISTORY

All information is confidential.

Check symptoms you now have or have had in the last year.

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/irritability
- Overwhelmed by life

MUSCLE/JOINT/BONES

- Tremors Cramps
- Swollen joints

Pain, weakness, numbness in

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

Other _____

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

EENT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Are you pregnant? _____

Check conditions you have or have had in the past.

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes
- Eczema
- Emphysema
- Heart disease
- Hepatitis
- Herpes
- HIV positive
- Kidney disease
- Liver disease

- Pneumonia
- Rheumatic fever
- Scarlet fever
- Seizures
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

How long has it been since you have had a complete medical exam?

6

LIFESTYLE

Check which substances you use and describe how much you use.

- Caffeine _____
- Drugs _____
- Alcohol _____
- Tobacco _____
- Sugar _____

Check if your work or lifestyle exposes you to these.

- Stress
- Insufficient sleep
- Very long working hours
- Long commuting times
- Heavy lifting or hazardous substances
- Other _____

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SIGNATURE

I certify that the information on this form is correct to the best of my knowledge.

Signature _____ Date _____