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Date: _____

Full Legal Name: _____ / _____ / _____
(First Name) (Last Name) (Middle Initial)

Preferred Name: _____ Age: _____ Date of Birth: _____

Telephone #: _____ / _____ / _____
(home) (work) (cell)

Address: _____

Mailing Address: _____

Email Address: _____ Gender: _____ Female _____ Male

Are you (check one): Single _____ Married _____ Other _____ Partner's Name: _____

Occupation: _____ (circle) Full-time / Part-time / Student / Retired

Employer / School: _____

Address: _____

Emergency Contact: _____
(Name) (Relationship)

_____ / _____
(Day Phone) (Evening Phone)

What is the best way to communicate with you between office visits? (Home, Cell, Work)

Is there any place you do **NOT** want me to leave a message? _____

Please be aware that e-mail is not a secure communication, subsequently, e-mail will not be used for any medical information or consults.

Insurance Information - Please provide copy of front and back of insurance card.

Group Insurance: Insurance Co: _____

Insured Full Legal Name: _____ DOB: _____

Driver's License Number: _____ Exp Date _____ Issuing State: _____

Confidential Health History Questionnaire

Name: _____ Date of Birth: _____

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of Onset: _____
2. _____ Date of Onset: _____
3. _____ Date of Onset: _____
4. _____ Date of Onset: _____

Name of Primary Care Physician: _____

What concern did you last receive health or medical care for? _____

What medications (prescribed or OTC), herbs, vitamins, supplements, etc are you currently taking?

Check those that you currently use:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Heart/Blood Medications | <input type="checkbox"/> Allergy Medication | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Hormones |

Do you have any known contagious diseases at this time? No Yes

If yes, what? _____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children	Paternal Grandparents	Maternal Grandparents
Ages (If living)							
Illnesses							
Age at Death							
Cause of Death							

Name: _____ Date of Birth: _____

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Please indicate the number of relatives who have/had the disease.

Cancer _____	Diabetes _____
Epilepsy _____	Heart Disease _____
High Blood Pressure _____	Stroke _____
Neuro Degenerative Disorders _____	Kidney Disease _____
Endocrine Disorders _____	Allergies _____
Asthma _____	Mental Illness _____
Arthritis _____	AutoImmune disorders _____

Have you ever had any of the following childhood illnesses (check if yes)

Scarlet Fever _____ Diphtheria _____ Rheumatic Fever _____ Mumps _____ Measles _____
German Measles _____

Have you had any immunizations? _____ Yes _____ No Negative Reactions? _____

Hospitalizations, Surgery, X-Ray and Special Studies

What hospitals, surgeries, x-rays or special studies have you had?

_____	year: _____	_____	year: _____
_____	year: _____	_____	year: _____
_____	year: _____	_____	year: _____
_____	year: _____	_____	year: _____
_____	year: _____	_____	year: _____

Allergies

Are you hypersensitive or allergic to foods, drugs or environmental substances? Please list:

Name: _____ Date: _____

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

GENERAL

Weight _____ Height _____ Weight 1 year ago _____ lbs
 Maximum(non pregnant weight) _____ When? _____

LIFESTYLE HABITS:

Main Interests and hobbies?

- _____ Exercise, what kind _____
 How often do you exercise? _____
 _____ Y _____ N Have a religious/spiritual practice
 _____ Y _____ N Average 6-8 hours of sleep
 _____ Y _____ N Have a supportive relationship
 _____ Y _____ N History of abuse
 _____ Y _____ N Major Traumas
 _____ Y _____ N Use of recreational drugs
 _____ Y _____ N Treated for drug dependence
 _____ Y _____ N Drink coffee
 _____ Y _____ N Drink black or green tea
 _____ Y _____ N Drink cola or other sodas
 _____ Y _____ N Add salt to your food
 _____ Y _____ N Eat refined sugar
 _____ Y _____ N Enjoy your work
 _____ Y _____ N Take vacations
 _____ Y _____ N Spend time outside
 _____ Y _____ N Watch TV?
 How much _____
 _____ Y _____ N Read?
 How often _____
 _____ Y _____ N Use alcoholic beverages
 # per week _____
 _____ Y _____ N Treated for alcoholism
 _____ Y _____ N Use tobacco currently
 _____ Y _____ N Use tobacco in the past
 How many years? _____
 How many packs per day? _____

Please shade in areas where you are experiencing pain on figures (if applicable).



