

Initial Visit – Health History

Date _____

Name _____ Birthdate ___/___/___ Age _____ Occupation _____

___ Single ___ Married ___ Living w/ partner **EMAIL** _____

of children _____ Their ages: _____

MEDICATION ALLERGIES: _____

WHAT PRESCRIPTION OR OTC MEDS DO YOU TAKE?

VITAMINS OR SUPPLEMENTS OR HERBALS? _____

WHAT OTHER TREATMENTS DO YOU GET? _____

What other doctors do you see? _____

Current and Past Medical History C = Current P = Past Please mark boxes appropriately

C	P		C	P		C	P	
		Heart Disease			Allergies			Marijuana/street drugs
		Blood Clots/Thromophlebitis			Cancer _____			Anxiety/Panic attacks
		Stroke			Liver problems			Depression
		High Blood Pressure			Anemia			Bipolar Disorder
		Mitral Valve Prolapse			Kidney Disease			Psychotic Disorder
		Heart Murmur			Asthma/Lung Disease			Borderline Personality
		STD (type) _____			Thyroid Disease			
		Mumps			Lupus			Men: Prostate Issues
		Osteoporosis/Osteopenia			Headaches/Migraines			Men: Testicular Cancer
		Arthritis			Skin Disease			Other: _____
		Diabetes			Urinary Problems			Other: _____
WOMEN ONLY:								
		Abnormal Vaginal Bleeding			Abnormal Pap Smear			Uterine Fibroids
		Fibrocystic Breasts			Vaginitis			
SURGERIES (and approx year)								
		REMOVED UTERUS			REMOVED OVARIES			CERVIX SURGERY
		MASTECTOMY R L			BREAST IMPLANTS			LIPOSUCTION
		GALL BLADDER			APPENDIX			SPLEEN REMOVED
		TONSILS OR ADENOIDS						
		OTHER:						

Reason for removal of any female organs: _____

FAMILY HISTORY OF ANY OF ABOVE: _____

Cigarettes Smoked per day _____ Weekly Alcohol Amount _____

Amount of weekly exercise: _____

Describe your diet: _____

Anything else we should know about you? _____

