PATIENT HISTORY

NAME:_____ **Age:**_____ **Date**_____

List your health problems in order of importance.

1. _____
2. _____
3. _____
4. _____

PERSONAL HISTORY: (Please check the relevant areas and give some detail below)

___Alcoholism
___Allergies
___Anemia
___Arthritis
___Asthma
___Cancer
___Colitis
___Diabetes
___Drug Addiction
___Gastrointestinal disorders
___Headaches
___Heart disorders
___Herpes genitalis
___High blood pressure
___Hypoglycemia
___Injury (serious)
___Liver disorders
___Psychological disorders
___Seizures
___Skin disorders
___Stroke
___Thyroid disorders
___Tuberculosis
___Venereal disease

Other and/or details

_____

_____

_____

NAME OF CURRENT OR MOST RECENT FAMILY PHYSICIAN:

_____

CURRENT PHYSICAL EXAM (within last year): ☐ **YES DATE**_____ ☐ **NO**

PREVIOUS HOSPITALIZATIONS/MAJOR ILLNESSES: – give dates and types of illness/operation

_____

_____

KNOWN ALLERGIES: (Foods, airborne, chemicals, or medications)_____

_____

MEDICATIONS & SUPPLEMENTS:_____
(Include prescription and non-prescription items, herbs, vitamins etc.)

_____

WEIGHT:
Present _____lbs **Usual** _____lbs **Wt change over last year: gained** _____lbs **lost** _____lbs

DIET AND HEALTH HABITS

List foods excluded from diet. _____
Satisfied with your diet as it is now? ☐ **Yes** ☐ **No Comments:** _____

Drug use? ☐ **Yes** ☐ **No If yes, how many years?**_____ **Type?**_____
Drink Alcohol? ☐ **Yes** ☐ **No If yes, amount per week?** _____
Drink coffee or soft drinks? ☐ **Yes** ☐ **No If yes, amount daily?** _____
Smoke cigarettes or use other tobacco products? ☐ **Yes** ☐ **No Daily amount?** _____
How many glasses of water do you drink per day?_____ **Are you constipated?** ☐ **Yes** ☐ **No**

Do You exercise regularly? ☐ **Yes** ☐ **No**
If yes, type and frequency?_____