Please fill out this information as accurately as possible as it is a part of your medical record.

Name_____
DOB_____
Email Address for Portal Use: _____
Reason for visit:_____
_____
_____
Primary Care Physician_____

Medical History (please circle all that apply)

Adrenal Fatigue Allergies ALS/MS Anemia Arthritis Asthma
Cancer (type)_____ COPD Depression or Anxiety
Diabetes Fatigue GERD Emphysema Hypothyroid Hyperthyroid
Hypertension Hyperlipidemia Heart Disease
Hormonal Imbalance Insomnia Migraines Osteopenia Osteoporosis
PCOS Postmenopausal Seizures Sleep Apnea Stroke
Vitamin B or D deficiency Other_____ No Health Problems

Surgical History (please circle all surgeries & add dates)

Appendectomy Breast Augmentation/Reduction Biopsy site_____
Bronchoscopy Carpal Tunnel CSection Colonoscopy Gall Bladder
Heart Surgery Hysterectomy with or without ovary removal
Hip/ Knee scope or replacement Tonsils/ Adenoids
Tubal Ligation Thyroid Other_____

Social History

Occupation_____Where employed_____
How Long employed_____ Hobbies/Interests_____
Retired? Yes No Stay @ home? Yes No
□Single □Married □Widowed □Divorced [] Student
Spouse/Partner Name_____- Their Occupation _____
City of Residence_____ Number of Children____
Ages of Children_____

Date of last Flu Shot_____ Other Vaccines_____
Date of Last Tetanus update_____

Family History

My mother is □alive □deceased Age_____
Health problems:_____
_____
My father is □alive □deceased Age_____
Health problems:_____
_____
Do your children have any health problems?
_____
Any family history of: If so, Who _____
□Heart disease □Stroke □Seizures
□Sleep Apnea □Insomnia □Asthma
□Emphysema □Allergies
□Cancer/Type:_____

Social Exposures

Do/Did you smoke? NO____ Yes, PPD_____
When did you quit?_____

Did you/do you use illict substances? Yes No
□meth □pot □other_____

Do you consume caffeine? Yes No
How many drinks per day?_____
□coffee □pop □energy drinks Tea

Do you drink alcohol? Yes No
How many drinks per day?_____Type_____

Do you work out? Yes No
If so, How often and what type?_____
_____

Do you wear your seatbelt? Yes No

How frequently are you exposed to the sun?
frequent occassional rare remote

Medication Allergies(Please list name & reaction)

_____
_____
_____
_____
Pharmacy Name and Location_____

Please list all medications and dosages

(Include supplements and over-the-counter meds)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____