DATE:_____ NAME:_____ BIRTHDATE: _____ AGE: _____

PREFERED PHARMACY _____

SEX _____ HEIGHT _____ WEIGHT _____

RACE _____ RELIGION_____

MARTIAL STATUS S M D W NUMBER OF CHILDREN _____

OCCUPATION_____

RECREATION _____

EXERCISE _____

ALCOHOL (TYPE & AMOUNT) _____

TOBACCO (TYPE & AMOUNT) _____

DRUGS (TYPE & AMOUNT) _____

COFFEE TEA _____

SODA/JUICE AMOUNT PER DAY _____

WATER: BOTTLED CITY WELL AMOUNT PER DAY _____

SLEEP (USUAL HRS) _____ AIDS TO SLEEP _____

BEDTIME _____ WAKE TIME _____

TIME OF FIRST MEAL/SNACK_____ TIME OF LAST MEAL/SNACK_____

NUMBER OF MEALS PER DAY _____

SNACK TYPES_____

DIET TYPE: VEGAN VEGETARIAN MEAT

ARE YOU INTRESTED IN LOSING WEIGHT? YES NO

ARE YOU INTRESTED IN REDUCING OR ELEMINATING MEDICATIONS FOR:

HIGH BLOOD PRESSURE YES NO

HIGH CHOLOESTEROL YES NO

HIGH BLOOD SUGAR YES NO

WHAT IS THE MAIN REASON FOR TODAY'S VISIT?

_____

_____

_____

ALLERGIES: _____

_____

| MEDICATIONS AND SUPPLEMENTS | REASON | DOSEAGE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PAST MEDICAL HISTORY—CIRCLE ANY YOU HAVE EVER HAD

PRE-DIABETES, DIABETES, OBESITY, FATTY LIVER, GOUT, HIVES, HIGH BLOOD PRESSURE, DEPRESSION, ANXIETY, CANCER, IBS, STD, HASHIMOTOS, BLOOD CLOTS, MENINGITS, RHEUMATIC FEVER, ANEMIA, ASTHMA, ARTHRITIS, BACK TROUBLE, BRONCHTIS, ULCER, PNEUMONIA, EMPHYSEMA, HEART DISEASE, HEMORRHOIDS, BLEEDING TENDENCY, BLOOD TRANSFUSION, HAY FEVER/SINUSITIS, HEPATITIS (YELLOW JAUNDICE), BLADDER INFECTIONS, KIDNEY DISEASE, GLAUCOMA, NOSE BLEEDS,

FAMILY HISTORY

LIST RELATION OF ANY BLOOD RELATIVE WHO HAS HAD THE FOLLOWING

DIABETES _____

HIGH BLOOD PRESSURE _____

CANCER _____

DEMENTIA _____

OBESITY _____

HEART ATTACK _____

STROKE _____

CHRONIC LUNG DISEASE _____

TUBERCULOSIS _____

KIDNEY DISEASE _____

ASTHMA _____

SEVERE ALLERGIES _____

SEIZURE _____

MIGRAINE HEADACHES _____

PEPTIC ULCER _____

BIPOLAR _____

SCHIZOPHRENIA _____

ANXIETY _____

DEPRESSION _____

| | PRESENT AGE, OR AGE AT DEATH | IF LIVING, HEALTH (GOOD, FAIR, POOR) IF DECEASED, CAUSE OF DEATH |
|---|---|---|
| FATHER | | |
| MOTHER | | |
| BROTHERS OR SISTERS | | |
| | | |
| | | |
| | | |
| | | |
| CHILDREN | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SURGERIES —- LIST YEAR

| | | | | |
|---|---|---|---|---|
| HIP | KNEE | SHOULDER | GALL BLADDER | BACK |
| APPENDIX | | STOMACH | HERNIA | HEART |
| HYSTRECTEMY | | TONSILS | BREAST | UTERUS/ |
| OVARY/TUBAL | | PROSTATE | THYROID | HEMORRHOIDS |
| VERICOSE VIENS | | OTHER_____ | | |

INJURIES:

HEAD, BROKEN BONES, BACK, OTHER _____

**HAVE YOU RECENTLY HAD THE FOLLOWING:** CIRCLE "YES" OR "NO", IF IN DOUBT LEAVE BLANK

**GENERAL**

| | | |
|---|---|---|
| TIRE EASILY, WEAKNESS | YES | NO |
| MARKED WEIGHT CHANGE | YES | NO |
| FEVER, CHILLS, SWEATS, ACHES | YES | NO |
| PERSISTENT FEVER | YES | NO |
| SENSITIVITY TO HEAT / COLD | YES | NO |

**SKIN**

| | | |
|---|---|---|
| ERUPTIONS(RASH) | YES | NO |
| CHANGE IN COLOR | YES | NO |
| CHANGE IN HAIR | YES | NO |
| CHANGE IN NAILS | YES | NO |

**EYES**

| | | |
|---|---|---|
| TROUBLE SEEING | YES | NO |
| EYE PAIN | YES | NO |
| INFLAMED EYES | YES | NO |
| DOUBLE VISION | YES | NO |
| WORN GLASSES | YES | NO |

**EARS**

| | | |
|---|---|---|
| LOSS OF HEARING | YES | NO |
| RINGING IN EARS | YES | NO |
| DISCHARGE | YES | NO |

**NOSE**

| | | |
|---|---|---|
| LOSS OF SMELL | YES | NO |
| FREQUENT COLDS | YES | NO |
| OBSTRUCTION | YES | NO |
| EXCESS DISCHARGE | YES | NO |
| NOSEBLEEDS | YES | NO |

**MOUTH**

| | | |
|---|---|---|
| SORE GUMS | YES | NO |
| SORENESS OF TONGUE | YES | NO |
| DENTAL PROBLEMS | YES | NO |

**THROAT**

| | | |
|---|---|---|
| POSTNASAL DRAINAGE | YES | NO |
| SORENESS | YES | NO |
| HOARSENESS | YES | NO |

**BREASTS**

| | | |
|---|---|---|
| LUMPS | YES | NO |
| DISCHARGE | YES | NO |

**CARDIO—RESPIRATORY SYSTEM**

| | | |
|---|---|---|
| COUGH, PERSISTING | YES | NO |
| SPUTUM (PHLEGM) | YES | NO |
| BLOODY SPUTUM | YES | NO |
| WHEEZING | YES | NO |
| CHEST PAIN OR DISCOMFORT | YES | NO |
| PAIN ON BREATHING | YES | NO |
| SHORTNESS OF BREATH | YES | NO |
| DIFFICULTY BREATHING WHILE LYING DOWN | YES | NO |
| LEG PAIN / SWELLING | YES | NO |
| BLUISH FINGERS OR LIPS | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO |
| PALPITATIONS | YES | NO |
| VEIN TROUBLE | YES | NO |

**DIGESTIVE SYSTEM**—INDICATE AVERAGE FOOD SELECTION FOR EACH:

BREAKFAST _____

LUNCH _____

DINNER _____

SNACKS _____

| | | |
|---|---|---|
| CHANGE IN APPETITE | YES | NO |
| DIFFICULTY SWALLOWING | YES | NO |
| HEARTBURN | YES | NO |
| ABDOMINAL DISTRESS | YES | NO |
| BELCHING OR EXCESS GAS | YES | NO |
| ABDOMINAL ENLARGEMENT | YES | NO |
| NAUSEA | YES | NO |
| VOMITING | YES | NO |
| VOMITING OF BLOOD | YES | NO |
| RECTAL BLEEDING | YES | NO |
| TARRY STOOLS | YES | NO |
| DARK URINE | YES | NO |
| JAUNDICE | YES | NO |
| CONSTIPATION | YES | NO |
| DIARRHEA | YES | NO |
| HEMORRHOIDS | YES | NO |
| NEED FOR LAXATIVES | YES | NO |

**GENITOURINARY SYSTEM**

| | | |
|---|---|---|
| INCREASE IN FREQUENCY OF URINATION | YES | NO |
| DIFFICULTY STARTING OR STOPPING | YES | NO |
| FEEL NEED TO URINATE WITHOUT MUCH URINE | YES | NO |
| UNABLE TO HOLD URINE | YES | NO |
| PAIN OR BURNING | YES | NO |
| BLOOD IN URINE | YES | NO |
| IMPOTENCE | YES | NO |
| LACK OF SEX DRIVE | YES | NO |
| PAIN WITH INTERCOURSE | YES | NO |

**ENDOCRINE**

| | | |
|---|---|---|
| THYROID TROUBLE | YES | NO |
| ADRENAL TROUBLE | YES | NO |
| CORTISONE TREATMENT | YES | NO |
| DIABETES | YES | NO |

**LOCOMOTOR**

| | | |
|---|---|---|
| MUSCLE CRAMPS | YES | NO |
| MUSCLE WEAKNESS | YES | NO |
| PAIN IN JOINTS | YES | NO |
| SWOLLEN JOINTS OR STIFFNESS | YES | NO |
| DEFORMITY OF JOINTS | YES | NO |

**NERVOUS SYSTEM**

| | | |
|---|---|---|
| HEADACHES | YES | NO |
| DIZZINESS | YES | NO |
| FAINTING | YES | NO |
| SEIZURES | YES | NO |
| ANXIETY | YES | NO |
| DEPRESSION | YES | NO |
| CHANGE IN SENSATION | YES | NO |
| MEMORY LOSS | YES | NO |
| POOR COORDINATION | YES | NO |
| WEAKNESS OR PARALYSIS | YES | NO |

**SLEEP DISORDERS**

| | | |
|---|---|---|
| SNORING | YES | NO |
| EXCESSIVE SLEEPINESS | YES | NO |
| INSOMINA | YES | NO |
| SLEEPLESSNESS | YES | NO |

**GYN –OB**

STARTED MENSTRUATING AT AGE _____

DATE OF LAST PAP TEST _____

INTERVAL BETWEEN PERIODS _____DAYS DURATION _____DAYS

FLOW: LIGHT NORMAL HEAVY DATE OF LAST PERIOD _____

PAIN WITH PERIODS YES NO DURATION _____

NUMBER OF PREGNANCIES _____

NUMBER OF MISCARRIAGES _____

NUMER OF BIRTHS _____

WEIGHT OF BABIES AT BIRTH _____