Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your Health Professional. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

NAME: _____

Address: _____

_____

Phone #_____ Email:_____

DATE OF BIRTH: _____ TODAY'S DATE: _____

Height_____ Weight_____

Blood Type (if known) A_____ B_____ AB_____ O_____

Gender: _____

List your four most important Health Issues and/or Wellness Goals.

1_____

2_____

3_____

4_____

Please list any medication allergies or reactions:

_____

_____

_____

Please check to indicate if you have ever had the following conditions:

Diabetes Y___N___ High blood Pressure: Y___N___ Asthma: Y___N___

Heart attack: Y___N___ Kidney disease: Y____N____ Hepatitis: Y____N____

Thyroid disease: Y___N___ Stroke: Y____N____ Depression: Y___N___

Emphysema: Y___N___ Seizures: Y___N___ Tuberculosis: Y___N___

Coronary Artery Disease Y___N___ Congestive Heart Failure Y___N___

Eye problems – type: _____

Cancer – type: _____

Other, please explain:

_____

_____

_____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location

Date:

_____

_____

_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

_____

_____

When was your last physical?

_____

MEDICAL HISTORY

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name: Dosage

_____
_____
_____
_____
_____

Are you under the care of any other health care professionals? Y ___N___
If so, Conventional _____or Alternative_____
If you answered yes please list names and reasons for using them.

_____
_____
_____
_____

Check any of the diseases that run in your family and please note who had it.

	Mother	Father	Sister	Brother	Grandma	Grandpa	Grandpa	Grandma	Child	Other
Cancer										
Diabetes										
Heart Disease										
High Blood Pressure										
High Colosterol										
Osteoporosis										
Mental Illness										
Stroke										
Thyroid Disease										
Other										

Other: _____

Comments:_____
_____

Do you smoke or use any tobacco products?

Yes ___ No ____ Quit ____ Amount per day? _____

For how many years? _____ Other forms of tobacco used? _____

Do you drink alcohol?

Yes ___ No____ Quit____

How much? _____ How often? _____

Have you regularly used other drugs? Yes / No

If yes, are you still using them? Yes / No

FAMILY HISTORY HEALTH HABITS

Are you currently married or living with a significant other? Yes / No

Who lives with you at home?

Are you employed? Yes / No

If yes, what kind of work do you do?_____

If no, is this by choice? Disability?_____ Other reasons?_____

Do you exercise more than 2 times per week? Yes / No

Do you often feel sad or depressed? Yes / No

Do you feel there is something seriously wrong with your body? Yes / No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? Yes / No

Do you have some form of church or spiritual support? Yes / No

Are you sexually active? Yes / No

If Yes, With: Men ____Women____ Both____

Do you feel you are at risk for HIV/AIDS or any other sexually transmitted disease? Yes / No

Do you have children? Yes / No

If Yes, How many children do you have? _____

---------- **Women only** ----------

Do you use any form of birth control?

If yes, which type / brand? _____

Have you ever been pregnant? Yes / No

How many times? _____

Miscarriages? How many? _____

Abortions? How many? _____

Do you have menstrual periods? Yes / No

If no, at what age did they stop? _____

If yes, are your periods regular? _____