



Patient Name: _____

D.O.B: _____

Health History

Please check all conditions you **currently** have or have had in the **past**:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hashimoto's Thyroiditis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cohn's Disease | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Diabetes- Type 1 | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Diabetes- Type 2 | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> COPD | <input type="checkbox"/> GERD / Acid Reflux | <input type="checkbox"/> HIV / Aids |
| <input type="checkbox"/> Other: _____ | | |

Family History

Please check any medical conditions that First Degree relatives have (e.g., Mother, Father, siblings)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Growth/Development |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bleeding disease | <input type="checkbox"/> Lung/Respiratory disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ovarian cancer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Psychiatric Cancer |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Severe allergies | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke | <input type="checkbox"/> Weight disorder |
| <input type="checkbox"/> Diabetes Type 1 or 2 | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> MS |
| | | <input type="checkbox"/> Endometriosis |
| | | <input type="checkbox"/> Other: _____ |

For any of the above conditions checked, please state the relationship:

If you are 13 years of age and older please answer the following question. Parents please answer this question for any smokers in the home for minors.

Tobacco Use: Never Former Smoker/ Quit _____ Yes #cigs _____/day
Alcohol Use: Never occasionally yes - amount per day _____

1. List any over-the-counter and prescribed medications you are currently taking:

Name:	Dose:

2. Please List any surgeries or hospitalizations you have had:

3. What do you have in your home? Check all that apply

Please state whether pet(s) are *indoor* or *outdoor*

- Dog(s)
- Cat(s)
- Cattle
- Rabbits
- Horse(s)
- Other _____
- Tile
- Carpet
- Linoleum
- Laminate
- Wood
- A/C
- Swamp Cooler

4. Please list any allergies to medication:

