Patient Name: _____
D.O.B:_____

Health History

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

☐ Asthma
☐ Anemia
☐ Anxiety
☐ Autoimmune Disorder
☐ Blood Transfusions
☐ Brain Tumor
☐ Bipolar Disorder
☐ Cirrhosis
☐ COPD
☐ Colon Cancer
☐ Coronary Heart Disease
☐ Cohn's Disease
☐ Depression
☐ Diabetes- Type 1
☐ Diabetes- Type 2
☐ Eczema
☐ Fibromyalgia
☐ GERD / Acid Reflux
☐ Hashimoto's Thyroiditis
☐ High cholesterol
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Hypertension
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ HIV / Aids
☐ Lupus
☐ Migraines
☐ Neuropathy
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Varicose Veins
☐ Other: _____

Family History

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

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