INTRODUCTION

Name___________________________ Home Phone ( )_____________ Work Phone ( ) ______________
Address__________________________________ City, State_______________________ Zip _____________
Email address_______________________________May I add your email to my mailing list? ______________
Age____ Date of Birth______________ Social Sec. # ______________ Marital Status M S W D Other
Do you have children? Y N If so, list ages ____
Occupation_______________________ Employer____
Work Address ____
Person to contact in case of emergency __________________________ Phone________________________
Who referred you to - or how did you hear about - the office? ____

Please describe the health concern(s) for which you came to our office.________________________________
____
____
____

Have you seen other doctors or health professionals for any of these concerns? Y N
If so, please list professional names and describe treatment(s) and outcome(s)___________________________
____
____
____

Name of Primary Care Physician_________________________________ Phone_________________________
Approx. date of most recent blood work__________ Do you have the results? Y N

Have you had ANY serious illnesses, injuries, or hospitalizations? Y N If so, please list below:

Year	Illness, Injury, Surgery	Hospital, City, State

Please list any conditions or diseases that tend to run in your family and include the blood relationship to you____
____

Are you currently taking ANY prescription medications? Y N If so, please list types and dosages if known____
____
____

Do you ever take OTC medications? Y N If so, list type, dosages, and frequency_______________________

Do you drink alcoholic beverages? Y N If so, please list type and frequency__________________________
____

Do you smoke cigarettes or use tobacco products? Y N If so, please describe frequency including # of years

---

Do you take recreational drugs? Y N If so, please list type(s) and frequency___________________________

Describe your current diet (i.e. omnivorous, vegetarian, vegan, other)________________________________
Describe a typical meal____
In your opinion, is your diet healthy? ____
# of meals/day___________________ Do you ever eat fast food? Y N If so, give frequency and describe typical meal ordered____
Do you drink caffeinated beverages? Y N If so, describe type, frequency, and quantity
____
____
Do you snack? Y N If so, list typical snacks and quantity ____
____
Do you exercise? Y N If so, please list type(s) of activity and frequency________________________________
____
Do you currently take any vitamins, herbs, or supplements? Y N If so, please list type and dosages if known
____
____
____
Do you have any known allergy to food, medication, or environmental agent? Y N
If so, please list allergen(s) and describe reaction(s)____
____
____
____
Have you suffered--past OR present--from any health conditions which have not been covered in this questionnaire? Y N If so, please describe____
____

Women Only:
Are you pregnant or think you could be? Y N Date of last menstrual period____________
Do you (or have you) experienced PMS, cramps, or heavy periods? Y N If so, please elaborate
____

All Patients:
I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ _____________________
Signature Date