Date:_____

Patient Name: _____ DOB: _____
Home Address: _____
Email Address: _____ Home phone:_____
Cell #:_____ Alternate #: _____
Name/phone of Primary Care Physician:_____ #_____
Address of PCP: _____
Emergency Contact:_____ #_____

Please list, in order of importance, your health concerns.

_____
_____
_____
_____
_____
_____
_____

Medical Information:
Please list any surgeries or hospitalizations along with date of occurrence.

_____
_____

Please list all medications and supplements you are taking or have recently taken.

_____
_____
_____

Please "check" all that apply.
Have sibling/parent/grandparent ever experienced…?
❑diabetes ❑heart disease ❑cancer ❑hypertension ❑kidney disease ❑liver disease
❑Tuberculosis ❑Stroke ❑Arthritis ❑Autoimmune disease ❑sickle cell or other anemias

Please read through the following chart of symptoms and "check" any that you currently experience or have in the past:

General: ❑hot ❑cold ❑chills ❑fever ❑sweats ❑ night sweats ❑weight loss ❑ weight gain ❑ fatigue ❑restless legs ❑snoring ❑excessive sleepiness ❑difficulty initiating sleep ❑difficulty maintaining sleep ❑anemia ❑excessive bruising or ❑ bleeding
Skin: ❑rashes ❑itching ❑excessive sweating ❑nail/hair abnormalities or changes ❑ discoloration
Head: ❑headaches/pain ❑head injury ❑migraines **Eyes**: ❑double vision ❑blurred vision ❑cataracts ❑vision changes ❑ eyestrain ❑ itchiness **Ears**: ❑discharge ❑hearing changes ❑tinnitus (ringing) **Nose**: ❑sinusitis ❑decreased smell ❑congestion ❑bloody nose ❑runny nose ❑allergies **Mouth/Throat**: ❑tenderness or lesions ❑sore throats ❑persistent hoarseness ❑difficulty swallowing **Neck**: ❑ pain or tenderness
CHEST: ❑ asthma ❑bronchitis ❑COPD ❑chronic cough ❑ productive cough: blood/mucus ❑ hyperventilation ❑ shortness of breath ❑ pain
CARDIOVASCULAR: ❑angina ❑Congestive Heart Failure ❑Coronary Artery Disease ❑dizziness ❑ Hypertension ❑ fainting ❑stroke ❑ atherosclerosis ❑ poor circulation
GASTROINTESTINAL: ❑constipation ❑diarrhea ❑black stools ❑gallbladder problems ❑nausea ❑vomiting ❑hemorrhoids ❑gas/bloating ❑jaundice ❑rectal bleeding ❑heartburn
GENITOURINARY: ❑rectal pain ❑pain with urination ❑blood in the urine ❑ frequent urination ❑discharge ❑change in frequency of urination ❑hesitancy ❑incontinence ❑chronic Urinary Tract Infections ❑Sexually Transmitted Infection ❑ kidney stones
<u>Females</u> OB/GYN: **# of pregnancies___ # of children ___** **Last Menstrual Period**: Last Pap: (date) _____ Last Mammogram: (date) _____
<u>BREASTS</u>: ❑discharge ❑enlargement ❑pain ❑tenderness ❑prior surgery or biopsy
NEUROMUSCULAR: ❑ muscle/nerve pain ❑tingling/numbness ❑arthritis ❑nervousness ❑vertigo ❑weakness
MENTAL/EMOTION: ❑depression ❑anxiety ❑panic attacks ❑rage ❑ memory loss

Please rate your quality of sleep and energy, with 10 being the absolute best, and 0 being the worst.

Sleep	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
General Energy:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Do you exercise…? _____

Type: _____

Frequency: _____

Restrictions? _____

What brings you joy in life? _____

_____

_____

Please list what you typically eat in a day:

Breakfast	
Lunch	
Dinner	
Snacks	
Fluid intake (amounts)	

How many bowel movements do you have daily? ____ Are they well-formed? _____

If you experience pain, please mark the location(s) of your pain/tenderness/discomfort on the following diagram: