Please fill out this information as accurately as possible;
it is part of your medical record.

Name_____ **DOB**_____
Email Address for Portal Use: _____
Reason for visit:_____
Primary Care Physician_____

Medical History (Please mark all that apply)

□NO Health Problems

□Adrenal Fatigue □Alcoholism □Allergies
□ALS/MS □Anemia □Arthritis □Asthma
□Cancer (type)_____ □COPD □Depression/Anxiety
□Diabetes □Fatigue □GERD □Emphysema
□Hypothyroid □Hyperthyroid □Hypertension
□Hyperlipidemia □Heart Disease □Hormonal Imbalance
□Insomnia □Migraines □Osteopenia
□Osteoporosis □PCOS □Postmenopausal □Seizures
□Sleep Apnea □Stroke □Vitamin B or D deficiency
□Other_____

Surgical History (Please mark all surgeries / years)

□Ablation_____ □Appendectomy_____
□Breast Augmentation/Reduction_____ □Biopsy site_____
□Bronchoscopy_____ □Carpal Tunnel_____ □C section _____
□Colonoscopy_____ □Gall Bladder_____ □Heart Surgery_____
□Hysterectomy with or w/o ovary removal_____
□Hip/ Knee scope/replacement_____ (site) _____
□Tonsils/ Adenoids_____ □Tubal Ligation_____ □Thyroid_____
□Wisdom Teeth_____ □Other_____

Social History

Occupation_____Where employed_____
How Long employed_____ City of Residence_____
Retired? □Yes □No Stay @ home? □Yes □No
Number of Children _____ Ages of Children_____
Hobbies/Interests_____
□Single □Married □Widowed □Divorced □Student
Spouse/Partner Name_____ Occupation _____

Vaccination Dates

Flu Shot_____ Pneumonia_____ Shingles _____ Tetanus_____

Family History (Please list parent health problems here)

My mother is □alive □deceased **Age**_____
Mother's Health problems_____
_____
My father is □alive □deceased **Age**_____
Father's Health problems_____
_____

Any family history of (Please note Who - NOT including parents)
□Heart disease_____ □Stroke_____ □Seizures_____
□Sleep Apnea_____ □Insomnia_____ □Asthma_____
□Emphysema_____ □Allergies_____ □Hypothyroid_____
□Cancer/Type:_____

Social Exposures

Do/Did you smoke? □ NO □ Yes, PPD_____
When did you quit?_____

Did you/do you use illict substances? □Yes □No
□meth □pot □other_____

Do you consume caffeine? □ Yes □No
How many drinks per day?_____
□coffee □pop □energy drinks □tea

Do you drink alcohol? □Yes □No
How many drinks per day?_____Type_____

Do you work out? □ Yes □No
How often and what type?_____
_____

Do you wear your seatbelt? □ Yes □No

How frequently are you exposed to the sun?
□frequent □occassional □rare □ remote

Medication Allergies (Please list name & reaction)

_____
_____
_____
_____

Pharmacy Name and Location_____

_____

Please list all medications and dosages

(Include supplements and over-the-counter meds)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____