



PATIENT HEALTH HISTORY

Full Legal Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Occupation: _____ Hours per week: _____

Employer: _____ Email Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred by (so I can thank them!) or how you heard about me: _____

Chief Complaint:

Reason for visit: _____

When did this condition begin? _____

Describe symptoms you have now: (we will go into detail at the initial consultation, so be brief here)

Please state diagnosis (if known): _____

What diagnostic tests (if any) have been done for this? _____

What treatment(s) have you already received for this condition? _____

Has any treatment helped? (if yes, please explain) _____

Do you have any other health concerns? (please list in order of importance):

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Allergies:

Are you allergic or hypersensitive to any foods, drugs, or environmental allergens? Yes No
If yes, please describe: _____

Chronic Illness:

Do you have any infectious/contagious disease? Yes No
If yes, please explain: _____

Are you currently suffering from any chronic illness? Yes No
If yes, please explain: _____

Major Medical:

Please list all hospitalizations, surgeries, significant illnesses, or traumas you have experienced in your life:

- 1) _____ Date: _____
- 2) _____ Date: _____
- 3) _____ Date: _____
- 4) _____ Date: _____
- 5) _____ Date: _____

Current Medications:

Please list all prescription medications (including hormones or birth control pills), over-the-counter medications, vitamins, herbs, or supplements you are currently taking and reason for taking them:

- 1) _____ dosage: _____ reason: _____
- 2) _____ dosage: _____ reason: _____
- 3) _____ dosage: _____ reason: _____
- 4) _____ dosage: _____ reason: _____
- 5) _____ dosage: _____ reason: _____
- 6) _____ dosage: _____ reason: _____

Nutrition:

Are you vegetarian or vegan? Yes No
Are you on any specific diets? Yes No If yes, please describe: _____

Other:

Do you smoke cigarettes? Yes No If yes, how many per day? _____
Do you drink alcohol? Yes No If yes, how many drinks per week? _____

*** Are you pregnant or have any reason to believe you may be pregnant?** Yes No

Is there anything else you would like me to know about you? _____

Overall, the state of your health is: excellent good average fair poor
How much change are you willing to make for improving your health? minimal some complete