

Name: _____ Birthdate: _____ Age: _____ Date: _____

Spouse, children names and ages _____

Occupation: _____

HISTORY

Chief Complaint: _____ LMP: (F) _____

Last medical exam/lab work _____ Physician name _____

Last dental exam _____ Mammogram/Pap Smear (F) _____ Colonoscopy _____

Bone Density _____ EKG/Treadmill _____

Major Conditions and When

High BP _____ Diabetes _____ High Cholesterol _____

Heart _____ Respiratory _____ Gastrointestinal _____

Genital/Urinary/Kidney _____ Musculoskeletal _____

Anxiety/Depression _____ Head/Ear/Nose/Throat/Thyroid _____

Gynecology/Menopause date (F) _____ Cancer _____

Surgery _____ Other _____

Slow down symptoms (energy, sex drive, muscle mass, fat mass) _____

Medications: _____

Supplements: _____

Drug Allergies: _____ Other Allergies: _____

Family History: Parents, siblings health: _____

Lifestyle: Exercise _____ Sleep _____ Alcohol _____ Smoke _____

What do you enjoy/relaxation _____ Stressors _____

Primary Health Objective _____

Diet

Typical breakfast _____

Snacks _____

Typical lunch _____

Drinks _____

Typical dinner _____

Sensitivities _____