Person Responsible Employed by______________________________ Occupation________________________
Business Address____ Phone_____________________________
Patient's Name____________________Age______ Height_____ Weight _____

Current medication you are taking: ____

____

____

Drug Allergies 1________________ Reaction____
2________________ Reaction____
3________________ Reaction____

Do you have any children? _____ If yes, how many?____ Menopausal? ______
Planning on a pregnancy? _____ Are you on any contraception?___ If so, which one?____________

FAMILY HISTORY

Lupus_____ Gout_____ Osteoarthritis _____ Stroke ______ Hypertension_____ Cancer _____
Rheumatoid Arthritis _____ Psoriasis _____ Heart Disease _____ Diabetes _____
Colitis _____ Spondylitis _____ Ankylosing _____

List any hospitalizations for Illness or Surgery and the approximate year:

____

____

CHECK OFF ONLY THE ONES THAT APPLY TO YOU
HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

__Skin Disease __Blood Disorder __Ulcer __Rheumatic Fever __Anemia
__Colitis __Lyme __Diabetes __High Cholesterol __Reflux
__Alcohol Abuse __Heart Attack __Lupus __Polyps __Drug Abuse
__Heart Murmur __Kidney Stones __Hepatitis __HIV Positive __Chest Pain/Angina
__Urinary Disorder __Heart Arrhythmia __Cirrhosis __Gout __Gynecology Problem
__Asthmas __Epilepsy __Arthritis __TB __ Lung Disease
__Hypertension __Stroke or TIA __Blood Clot __Mental Disorder __Thyroid Abnormality
__Miscarriages __Rheumatoid Arthritis __Gall Bladder Disease __Fibromyalgia
__Sexually Transmitted Disease __Cancer of ____________________ __Chicken Pox/Shingles
__Other____________________

Do you smoke? ________________ If so, how much? ______________ If you quit, when?________________
Do you drink alcohol ___________ If so, how often?________________
Are you on any special diet?________________ If so, what kind?____________________________________
(example; Low Calorie, Low Cholesterol, Diabetic, Low Salt)
Any Drug Use?____________________________