

Patient: _____ Date: _____ Acct: _____

PATIENT HISTORY

How much water do you drink daily? _____

Do you drink alcohol? Y N How much? _____

Do you drink coffee? Y N How much? _____

Do you drink pop? Y N How much? _____

Do you smoke? Y N How many per day? _____ How long? _____

Do you exercise? Y N How often? _____ Type: _____

Do you have allergies? (Specify) _____

Have you ever suffered or been diagnosed as having: (circle yes or no for each)

Y N	Broken/Fractured Bones	Y N	Osteoporosis	Y N	Eating Disorder
Y N	Circulatory Problems	Y N	Epilepsy	Y N	Alcoholism
Y N	Rheumatoid Arthritis	Y N	Pacemaker	Y N	Drug Addiction
Y N	Osteoarthritis	Y N	Strokes	Y N	HIV Positive
Y N	Congenital Disease	Y N	Cancer	Y N	Sleep Disorder/Insomnia
Y N	Excessive Bleeding	Y N	Tumors/Fibroids	Y N	High/Low Blood Pressure
Y N	Seizures/Convulsions	Y N	Diabetes	Y N	Fibromyalgia
Y N	Coughing Blood	Y N	Ulcers	Y N	Depression

If you marked yes to any of the above, please explain: _____

Have you ever been in a motor vehicle accident or had any traumas? If so, please describe:

When was your last Physical Exam? _____ X-rays? _____

Medications

Name of Medication	Reason for Taking	Non Rx Strength	Rx Strength	Date Started	Date Stopped	Prescribed By
						Doctor Self
						Doctor Self
						Doctor Self
						Doctor Self
						Doctor Self

Are you taking any vitamins? Y N Types of vitamins: _____

