



MEDICAL HISTORY

Patient Name (Last, First, Initial)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Today's Date
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PAST MEDICAL HISTORY

Please check any conditions for which you have previously been diagnosed and treated (or are still currently being treated for):

- | | |
|--|--|
| <input type="checkbox"/> Diabetes (specify: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pre-diabetes ("borderline diabetes") | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Heartburn/stomach ulcer |
| <input type="checkbox"/> Insulin resistance / Metabolic syndrome | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Polycystic ovarian syndrome (PCOS) | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Celiac disease / gluten sensitivity |
| <input type="checkbox"/> Heart attack (specify year: _____) | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Stroke (specify year: _____) | <input type="checkbox"/> Kidney problems (other than UTI) |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Heart murmur / valve problems | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer (specify type: _____) |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Blood clots (specify: <input type="checkbox"/> legs <input type="checkbox"/> lungs) | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Cholesterol problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Thyroid disorders (specify: <input type="checkbox"/> Low <input type="checkbox"/> High) | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Vitamin D deficiency | |
| <input type="checkbox"/> Other (specify: _____) | |

Have you been diagnosed with non-Rx allergies? No (if Yes, specify: food and/or respiratory [e.g.: hay fever, pollen, dust])

Have you ever been *tested* for sleep apnea? (specify: No Yes, year tested: _____)

Have you ever been *diagnosed* with sleep apnea? (specify: No Yes)

Do you use CPAP/BiPAP? (specify: No Yes)

PAST SURGICAL HISTORY

Weight loss surgeries:

- Roux-en-y
- Gastric sleeve
- Lap band

Any other major surgeries: _____

WELLNESS AND HEALTH MAINTENANCE HISTORY

Most recent lab testing (specify year): _____

Last pap smear (specify year): _____

If over age 50, date of last colonoscopy: _____

Last mammogram (specify year): _____

Menopause (specify year): _____

SOCIAL HISTORY

Occupation (past, if retired): _____ Retired / Not currently working

Spouse / significant other name: _____

Marital status: _____

Age(s) of any children living at home: _____

Tobacco use: _____

Drug and alcohol use:		Currently use	Previously used	Frequency per week	If stopped, when
alcohol		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
recreational drugs		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
medication misuse		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____

FAMILY HISTORY

Has anyone in your family (blood relatives) had any of the following? (Check appropriate box)

	Mother	Father	Grand-parent	Brother/Sister	Other (specify)
Diabetes or borderline diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease/heart attack/congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cholesterol problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety, depression or mental health issues (e.g., depression, bipolar disorder, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug/alcohol/medication abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICAL PROVIDER INFORMATION

Primary care provider: _____

Specialist(s): _____

SYMPTOMS (REVIEW OF SYSTEMS)

Please check any issues that you are currently experiencing, or have experienced within the past two months:

- | | |
|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Extreme hunger |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Strong food cravings |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Persistent difficulty sleeping | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Mobility problems | <input type="checkbox"/> Heavy or painful periods |
| <input type="checkbox"/> Pain in joints (specify): _____ | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Rash/irritations in skin folds | <input type="checkbox"/> PMS |

