ALLERGIES: Please check and list all allergies.

 Food: ____________________
 Medications: ____________________
 Seasonal/Other ____________________

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
Antacids		
Antibiotics		
Antidepressants		
Anti-Diabetics		
Anti-Inflammatory		
Blood Pressure Lowering Meds.		
Cholesterol Lowering Meds.		
Hormone Replacements (HRT)		
Oral Contraceptives		
Other		

SCARS/SURGICAL PROCEDURES: List all scars and surgical procedures you have had. ____________________

____

____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? Y N If yes, who recommended them?____________________

HABITS:

	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Soda/Diet Soda				
Tobacco				
Drugs				
Stress Level				

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise					____	____
	8+ hrs.	7-8 hrs.	6-7 hrs.	5-6 hrs.	<5 hrs.	
Sleep						
	5+	4	3	2		
Meals / day						
	64+ oz.	32-64 oz.	16-32 oz.	< 16 oz.		
Water / day						

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking / Moving Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Sibling, **X** = self)

_____Alcoholism
_____Anemia
_____Cancer
_____Cold Sores
_____Deep vein thrombosis
_____Detached retina
_____Diabetes
_____Eczema
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Heart disease
_____HIV / AIDS
_____Miscarriage(s)
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic fever
_____Stroke
_____Tumor(s)
_____Ulcer(s)
_____Other: ____________________
____
____

____
Patient's Printed Name

____________________ ____________________
Patient's Signature Date