Name________________________________Date______________________

Allergies: Date of Onset Reaction Description

Allergies	Date of Onset	Reaction Description

Family History:

Relation	Condition

Hospitalization:

Reason	Name of Hospital

Medications: (can supply list)

Medication	Form and Strength	Quantity	Frequency	Start Date	Physician

Nutritional Supplements:

Manufacturer	Frequency	Quantity	With Water Y/N

Occupational History:

Job Description | Work Schedule | Activities

___

___

Physical Stress Level: Low Med High
Injured on job? Yes No

Recreational History:

Activity | Frequency | Current Difficulty Level 1-10 | Prior Difficulty Level 1- 10

___

___

___

___

Check any symptoms you have had and whether it is past or present.

	Past	Present		Past	Present
Recent weight change	□	□	Loss of Appetite	□	□
Weakness/Fatigue	□	□	Bowel/ Bladder Problems	□	□
Fever	□	□	Bloody Stools	□	□
Chills	□	□	Nausea/ Vomiting	□	□
Night sweats	□	□	Frequent Urination	□	□
Tinnitus R/L	□	□	Burning Urination	□	□
Hearing loss	□	□	Blood in Urine	□	□
Vertigo	□	□	Sexual Dysfunction	□	□
Dizziness	□	□	Abnormal Menses	□	□
Double Vision	□	□	Headaches	□	□
Blurred Vision	□	□	Seizures	□	□
Rhinitis	□	□	Fainting Spells	□	□
Hoarseness	□	□	Memory Problems	□	□
Speech Difficulties	□	□	Thyroid Problems (hypo/hyper)	□	□
Joint Swelling	□	□	Diabetes	□	□
Cramps	□	□	Excessive Thirst	□	□
Arthritis	□	□	Excessive Hunger	□	□
Gout	□	□	Coldness (upper/ lower)	□	□
Palpitations	□	□	Anemia	□	□
Chest Pain	□	□	Depression	□	□
Cough	□	□	Nervous	□	□
Difficulty Breathing	□	□	Anxious	□	□
Coughing Up Blood	□	□	Insomnia	□	□

Smoking History:

Currently Smoke Y N Years Smoked:___________ Packs per Day______
Level of Interest in Quitting 1 2 3 4 5 6 7 8 9 10
Quit _____years ago.

Social History:

Alcohol Consumption ☐ None ☐ Socially ☐ Daily ☐ Daily ☐ Rarely
Coffee Consumption ☐ None __ cups per day
Soda Pop Consumption ☐ None __ cans per day
Water Consumption ___ glasses per day
Sleep Amount ___ hours per night
Pain Reliever Frequency ____________ tablets per day _____________ tablets per day
Recreational Drug Use ____
Healthy Eating Rank 1 2 3 4 5 6 7 8 9 10
Exercise Frequency _________________ Type ______________________
Physical Stress Level 1 2 3 4 5 6 7 8 9 10
Emotional Stress Level 1 2 3 4 5 6 7 8 9 10
Major Stressors ____
Things to Improve ____
Other Health Goals ____

Past Surgery:

Date	Surgery Details	Inpatient	Out Patient

Height______________ Weight________________ Blood Pressure (if known) ________