



General Patient Information

Welcome to our practice! Please take a moment to fill out the following health questions:

Patient Name: _____

Today's Date: ___ / ___ / ___

Preferred Name: _____

Prior medical problems - check all those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |

Prior surgeries - circle all those that apply, give dates if possible:

- | | |
|---|--|
| <input type="checkbox"/> Hysterectomy ___ / ___ / ___ | <input type="checkbox"/> Tonsillectomy ___ / ___ / ___ |
| <input type="checkbox"/> Appendix removal ___ / ___ / ___ | <input type="checkbox"/> Gallbladder removal ___ / ___ / ___ |
| <input type="checkbox"/> Prostate surgery ___ / ___ / ___ | <input type="checkbox"/> Breast surgery (cancer? <input type="checkbox"/> benign? <input type="checkbox"/>) ___ / ___ / ___ |
| <input type="checkbox"/> Other: _____ | |

Primary Care Physician (PCP): _____

Referring physician if different from above: _____

Do you drink milk or dairy products? Yes No If yes, how many servings per day? _____

Do you use caffeine (coffee, tea, soda)? Yes No If yes, how many servings per day? _____

Do you drink alcoholic beverages such as wine, beer, or mixed drinks? Yes No
If yes, how many servings per day? _____

If you have ever used tobacco:

Tobacco Use: Current Former Never Type: cigarettes/cigars chewing tobacco snuff

How much a day? _____ Age quit: _____

Years used: _____

Ever tried to quit? Yes No

Do you have a family history of - check all that apply and list family member next to disease.

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Thyroid Disorders _____ | <input type="checkbox"/> Colon Cancer _____ |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Obesity (overweight) _____ |
| <input type="checkbox"/> Skin Disease _____ | <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Infertility _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Coronary Heart Disease (Heart Attack or Surgery) _____ | <input type="checkbox"/> Osteoporosis/Hip Fractures _____ | |
| <input type="checkbox"/> Other: _____ | | |