

*Please read, complete, and bring with you for your initial consultation. Use back if necessary.*

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of most recent complete medical exam: \_\_\_\_\_ & blood work: \_\_\_\_\_

**Medications:** Please list all current medications and significant / long-term past medications. Also include non-prescription drugs, vitamins, minerals, herbal, and homeopathic supplements.

| Name | Dose<br>(e.g. mg) | Route<br>(e.g. oral) | Frequency | Reason Taking & Side Effects |
|------|-------------------|----------------------|-----------|------------------------------|
|      |                   |                      |           |                              |
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|      |                   |                      |           |                              |

**Health History:** Please check all illnesses you and/or your immediate family members have and/or had. Please indicate if it is you (√), your mother (M), father (F), sister (S), brother (B), grandmother (GM), grandfather (GF), child (C), or grandchild (GC).

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizure Disorder  |
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Hypoglycemia      |
| <input type="checkbox"/> Elevated Cholesterol Levels | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Mental Illness    |
| <input type="checkbox"/> Stroke                      | Type: _____                              | Type: _____                                |
| <input type="checkbox"/> Diabetes                    | Type: _____                              | Type: _____                                |
| <input type="checkbox"/> Allergies                   | Type: _____                              | Type: _____                                |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Suicide           |
| <input type="checkbox"/> Kidney Disease / Stones     | <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Angina / Chest Pain         | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Osteoporosis      |
| <input type="checkbox"/> Cirrhosis / Liver Disease   | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Ulcers / Stomach Disease    | <input type="checkbox"/> Lung Disease    | <input type="checkbox"/> Chicken Pox       |
| <input type="checkbox"/> Polio                       | <input type="checkbox"/> STDs            | <input type="checkbox"/> Yeast Infection   |
| <input type="checkbox"/> Urinary Tract Infection     | Type: _____                              | <input type="checkbox"/> Other: _____      |

*During your initial consultation, we will cover medical illnesses, hospitalizations, surgeries, gynecological health, mental/emotional health, and health maintenance (immunizations and screening tests). Please come prepared to discuss these topics. **Thank You!***