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 (e.g. mg)	Route (e.g. oral)	Frequency	Reason Taking & Side Effects

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).

____ Hypertension
____ Heart Disease
____ Elevated Cholesterol Levels
____ Stroke
____ Diabetes
____ Allergies
____ Asthma
____ Kidney Disease / Stones
____ Angina / Chest Pain
____ Cirrhosis / Liver Disease
____ Ulcers / Stomach Disease
____ Polio
____ Urinary Tract Infection

____ Thyroid Disease
____ Anemia
____ Cancer
Type: _____
Type: _____
Type: _____
____ Headaches
____ HIV/AIDS
____ Hepatitis
____ Arthritis
____ Lung Disease
____ STDs
Type: _____

____ Seizure Disorder
____ Hypoglycemia
____ Mental Illness
Type: _____
Type: _____
Type: _____
____ Suicide
____ Bleeding Disorder
____ Osteoporosis
____ Tuberculosis
____ Chicken Pox
____ Yeast Infection
____ 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!***