DATE ___________________

PATIENT PROFILE

Last Name:__________________________________ First Name:_________________________________

Nickname: __________________________________ Birthdate: ____________________ Sex: ________

A note to my patients: Please complete this two-sided questionnaire as thoroughly as possible. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	How long has this been a problem?
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit today? ____

____

Please list prescription medications that you are currently taking, with dosages:

1.___________________________ 2.___________________________ 3. ___________________________

4.___________________________ 5.___________________________ 6. ___________________________

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1.___________________________ 2.___________________________ 3. ___________________________

4.___________________________ 5.___________________________ 6. ___________________________

Please list any severe or life-threatening allergies and your reactions: _________________________________

____

PAST MEDICAL HISTORY:

Hospitalizations: ____

____

Serious Illnesses and Injuries: ____

____

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Date of last physical/annual exam ________________ Date of last blood tests: ________________________

Who is your Primary Care Physician?____

Who is your Health Insurance Carrier?____

PERSONAL AND FAMILY MEDICAL HISTORY:

For grandparents, use P for paternal, M for maternal i.e. PGM = paternal grandmother

Check those that apply:	Yourself	Mother	Father	Grand parents	Sister/ Brother	Spouse	Children
Alcoholism/Addictions							
Allergies							
Alzheimer’s							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer (**what type?**)							
COPD / Emphysema							
Depression							
Diabetes							
Eczema							
Epilepsy							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV / AIDS							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraines/Headaches							
Stroke							
Thyroid disorder							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY:

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s) ____________________

DIET & LIFESTYLE:

Do you exercise regularly? ❑Yes ❑No What type? ____

How long? ___________________________________ How often?_________________________________

How much / how often do you use the following:

Tobacco?________________________ Coffee/black tea/cola?________________________________

Alcohol?_________________________ Recreational drugs?___________________________________

Do you follow any particular diet regimens or restrictions? If yes, please describe: ________________________

____

Do you have any food cravings?____

How much / how often do you eat the following:

Fish?_________________________ Meat?_________________________________

Dairy?________________________ Vegetables?_____________________________

Fruit?_________________________

	Food on a typical weekday	Food on a typical weekend
Breakfast Time:		
Lunch Time:		
Dinner Time:		
Snack Time:		
Snack Time:		

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