PATIENT PROFILE

Name: ____ Date: ______________

Age: _______ Birthdate: _____________ Sex: F_____ M_____

Address: _______________________________City: ____________________St:_____ Zip: _________

Home Phone: _________________ Work Phone: _________________ SS#________________________

Occupation: ____ Full Time____ Part Time____ Retired____

In Case of Emergency Notify: _________________________________ Relationship: ________________

Address: ____ Phone #:_______________________

Family Physician: ____ City: _________________________

Referred By: ____

Current Health Problems:

What are the most important health problems you would like to talk about today?

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Health History: Check relevant areas and give brief details on the last page.

__Alcohol/Drug Abuse

__Allergies

__Anemia

__Arthritis

__Asthma

__Cancer

__Cardiovascular (heart) disorder

__Endocrine (gland) disorder

__G.I. (digestive) disorder

__Immune/Blood disorder

__Musculoskeletal disorder

__Diabetes

__Gout

__Herpes Genitals

__Heart Disease

__High Blood Pressure

__Hypoglycemia

__Nervous System Disorders

__Psychological Problems

__Pulmonary (lung) disorder

__Skin disorder

__Urinary/Genital disorder

__ Injury (serious)

__Liver Disease

__Stroke

__Thyroid Disease

__Tuberculosis

__Venereal Disease

Other:

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____

Family History: Check for blood relatives and list your relationship.

___ Alcoholism
___ Anemia
___ Asthma
___ Hemophilia
___ Cancer
___ Diabetes
___ Glaucoma
___ Gout
___ Hay Fever
___ Heart Disease
___ High Blood Pressure
___ Hypoglycemia
___ Mental Illness
___ Seizure or Epilepsy
___ Sickle Cell Anemia
___ Skin Disorders
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Venereal Disease

Other significant family health problems? ____

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Female only:

Regular menstrual cycles: Yes____ No____

Average length of menstrual cycles (from period to period)? __________ Days.

Painful menstruation? Yes ____ No ____

Excessive flow? Yes ____ No ____

Prolonged flow? Yes ____ No ____

Premenstrual symptoms? Yes ____ No ____

Hysterectomy? Yes____ No ____

If yes, Total? _____ Partial? _____ When? __________

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you ever used birth control pills? Yes____ No____

If yes, when and for how long? ____

Please briefly explain any health history that you checked above:

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Hospitalizations: Dates and type of illness/injury/operation.

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Medications and Supplements: Include prescription and nonprescription drugs, herbs, vitamins, minerals, etc.

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Allergies:

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HEALTH HABITS: Primary interests, hobbies or activities:

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Do you get regular exercise? Yes____ No____ If yes, in what form and how often?

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Do you drink alcohol? Yes____ No____ Use other recreational drugs? Yes____ No____

If yes to either question, how much, how often and what kind?

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Do you use tobacco? Yes____ No____ If so, what kind, how much and for how long?

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Do you drink coffee? Yes____ No____ If yes, how much?

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How many meals do you usually eat per day? _______ How many snacks? _______

What kinds of foods make up your usual diet? ______________________________________

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