Health History:

	Self	Family		Self	Family		Self	Family
AIDS/HIV	__	___	Hepatitis C	__	___	Numbness in arms & hands	__	___
Anemia	__	___	Heart disease	__	___	Numbness in legs or feet	__	___
Arthritis	__	___	Hernia	__	___	Osteoporosis	__	___
Asthma	__	___	High Blood Pressure	__	___	Pacemaker	__	___
Bleeding easily	__	___	High Cholesterol	__	___	Rheumatoid Arthritis	__	___
Breast Lump	__	___	Hip pain	__	___	Scoliosis	__	___
Cancer	__	___	Kidney disease	__	___	Sleeping problems	__	___
Depression	__	___	Liver problems	__	___	Stomach problems	__	___
Diabetes	__	___	Low back pain	__	___	Stroke	__	___
Emphysema/COPD	__	___	Menstrual problems	__	___	Systemic lupus	__	___
Gallbladder problems	__	___	Mid back pain	__	___	Thyroid problems	__	___
Hepatitis A	__	___	Migraine headache	__	___	Ulcer	__	___
Hepatitis B	__	___	Multiple Sclerosis	__	___	Lung disease	__	___
			Neck pain	__	___			

Date of last physical exam _____ (Women) Are you Pregnant? _____ Nursing? _____ Using any birth control?_____

Primary Doctor_____ Address & Phone_____

Please list your current medications and for what condition(s) they have been prescribed:

_____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____

Daily Habits

How often do you exercise? _____ What type of exercise? _____

What do your daily work habits include? (sitting, standing, light labor, heavy labor, computer work)

_____

Do you smoke? _____ How much per day _____

Do you consume alcohol? Never ____ Occasionally ____ Frequently (more than 3 days/week) ___ Daily ____

How much coffee or caffeine beverages do you consume on a daily basis? _____

I give you permission to share information regarding my care with my primary care physician as you see beneficial.

Signature _____ Date _____