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Health History

Lab Work needed for New patients (must be within last 3 months):

Healthy on NO medications - CMP & TSH

Healthy on medication(s) - CMP, TSH, Urinalysis

On Cholesterol - CMP, TSH, Urinalysis & Lipid Panel

• Diabetic Clients - CMP, TSH, Urinalysis, & HgA1C

Gastric Bypass/Lap Banding – CBC w/DIFF platelets, CMP, TSH, Urinalysis & Lipid

Date:	
Patient Information:	
Name:	Date of Birth:
Address:	Age:
City, State:	Height:
Zip Code:	Actual Weight:
Home Phone:	Goal Weight:
Cell Phone:	BMI:
Email Address:	Weight Range:
Employer Information:	
Company Name:	List Medications/Dose/Frequency:
Occupation:	
Email Address:	
Phone Number:	
List Surgeries:	List Allergies to medications:
Family/Internal Medicine Physician	
Full Name:	Cardiologist
Address:	Full Name:
Phone Number:	Address:
Fax Number:	Phone Number:
	Fax Number:
Other Physicians	
Full Name:	List any pertinent family history of medical problems
Address:	
Phone Number:	
Fax Number:	

Do you see a physician for any condition presently? Yes No

Check the following that apply:

Cardiac

- History of irregular heartbeats
- Pacemaker or Defibrillator implanted
- Open Heart Surgery
- History of Heart Disease
- High Blood Pressure
- Diabetic (insulin/medication/diet)

- Vision Problems
- Blood Thinner _____
- Stress Test
- Chest Pain
- Bypass
- Congestive Heart Failure
- HBP controlled with medication
- Stroke
- Cardial Cath
- Swelling of Extremities
- Valve Replacement
- HBP not controlled
- Weakness
- Vision Problems
- Blood Clots
- Pulmonary Embolus
- Blood clotting abnormality (list type):

Endocrine

- Thyroid
 - High Low
- Adrenal Gland Problems
- Parathyroid Problems
- Hair thinning or falling out

Neurologic

- Current Seizures
Date of last seizure _____
- Epilepsy
- Brain Lesion
- Brain Tumors
- Parkinsons
- Ringing in Ears
- Difficulty Sleeping
- Lupus
- Fibromyalgia
- Depression
- Panic Attacks
- Bipolar
- Eating Disorder
- Schizophrenia
- Migraine
- Headaches

Pulmonary

- Asthma
 - Have you ever been hospitalized for an asthmatic attack? Yes No
 - Use Inhaler
If yes, how often? _____
- Smoker
- Emphysema
- Shortness of Breath
- Tuberculosis

GI

- Ulcer
- GI Bleed
- Constipation
- Diarrhea
- Colitis
- Crohns Disease
- Diverticulosis
- Bloody Stool
- Tarry Stool
- Liver Disease
- Cirrhosis
- Hepatitis (all)
- Drink Alcohol
- Recovery Alcoholism

GU

- Urinary Tract Infections
- Kidney Stones
- Dialysis
- Renal Failure

Ortho

- Arthritis
- Rheumatoid
- Osteoporosis
- Gout
- Carpal Tunnel
- Multiple Sclerosis
- Rheumatism

General

- Sleep Apnea
- Use CPAP machine
- Tumor
- HIV/Aids
- Cancer
Type _____
- Radiation
- Chemo

Females

- Missed Periods
 - Menstrual Pain
 - Excessive Bleeding
 - Hot Flashes
 - Infertility
 - Birth Control
 - Hysterectomy
 - Breast Feeding
 - Endometriosis
 - Ovarian Cyst
 - Polycystic Ovarian Syndrome
 - Mammogram
 - Breast Exam
 - Enlarged Ovaries
- Date of last period _____
- Date of last pap smear _____

Males

- Prostate Problems
- Androgen Dependent Tumors

Vital Signs

_____ Blood Pressure

_____ Heart Rate

_____ Respiration

Physician/NP Signature: _____ Date _____

Patient Signature: _____ Date _____