Today's Date: _______________

Patient's Full Name:				
Date of Birth:	Height:	Age:	Sex:	Marital Status:
Street Address:			City and State:	Zip Code:
Home Phone:	**Cell Phone:**		**E-mail Address:**	
Occupation:				
In the case of Emergency who should we call: Phone #				
Relative other than at your home address:			Relationship:	
Children's Names and Ages:			How did you hear about us?	

PATIENT HISTORY (*please check all that apply*)

General	**Head / Ears / Nose / Throat**	**Pulmonary**
Unplanned Weight Change Fatigue Weakness	Visual Problems Glasses / Contacts Cataracts Hearing Problems Sinus problem Neck pain Thyroid Problem	Cough Wheezing Shortness of Breath Positive TB Test Snoring Headache Asthma Sleep Apnea Insomnia

Cardiac	**Gastrointestinal**	**Genitourinary**	**Metabolic**
Chest Pain Irregular Heart Beat Palpitations Congestive Heart	Abdominal Pain Trouble Swallowing Nausea/Vomiting Dark / Black Stool Yellow Jaundiced Diarrhea Constipation Bright Red Blood in Stool Hemorrhoids Stomach Ulcers Heartburn or Reflux	Blood in Urine Hesitancy Kidney Stones Frequent Urination Prostate Problems Discomfort-Urination	High Blood Pressure Diabetes High Cholesterol

Patient Initial_________

Hematological	**Neurological**	**Musculoskeletal**	**Psychological**	**Gynecologic**
Abnormal Bleeding Easy Bruising Blood Clots in Legs/Lungs HIV, AIDS Nose Bleeds Hepatitis B Hepatitis C	Headaches Dizziness Passing Out Seizure Epilepsy Stroke	Joint Pain Swelling Back Pain Pain in Legs Leg Ulcers Varicose Veins Leg Cramps	Depression Anxiety psychiatric /psychological treatment?	Breast Pain Breast Lumps Breast Discharge Menopause Irregular Menstural Cycle Pregnancy

List **ALL** prescriptions and over-the-counter medications presently using:

List **ALL** prior surgeries and dates:

List **ALL DRUG** allergies:

Family Medical History (please check all that apply)

Heart Disease/Stroke　　Diabetes
High Cholesterol　　Obesity
High Blood Pressure　　Cancer
Other:

PLEASE LIST ALL THE DIET PROGRAMS YOU HAVE USED IN THE PAST

Program (Weight Watchers, Atkins, etc.):

When and How Long?

Total Weight Lost?

Pounds Regained?

Patient Initial__________

Dietary History:
Do you eat Breakfast?

Do you eat lunch?

Do you eat dinner?

How many times a day do you eat:
Fruits:
List types:

Vegetables:
List types:

How many PER WEEK do you eat Snack Food (Chips, Pretzels…)
- o Never
- o 1-2 times/week
- o 3-4 times/week
- o 5-6 times/week
- o Daily

How many PER WEEK do you eat Sweets (Cake, Candy, ice cream…)
- o Never
- o 1-2 times/week
- o 3-4 times/week
- o 5-6 times/week
- o Daily

How many ounces of the following beverages do you drink in a day:

________skim milk	________low fat milk	_______whole milk
________regular soda	_______diet soda	
________coffee	________tea	________water
________wine	________beer	________hard liquor

How often do you eat during day?

Who prepares the meals at your home?

Who does the food shopping?

How many people in your household?

How many times a month do you food shop?

Where do you usually shop?

Do have problem with overeating?

Do you exercise? If “Yes”: How many Days a week? For how many hours? What do you do for exercise?
Smoking History: Do You Smoke? How many Packs a day do you smoke? How many years have you been smoking?

Patient Initial_________