

# Christine M. Bowen, N.D.

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## NEW PATIENT REGISTRATION FORM

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with Dr. Bowen.

### PATIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender: M F Other
Address:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
(zip)	Number of people in household:	children?
Occupation:	Employer / School:	
Education completed:	<input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other	
Travel Outside US?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where / When?

### CONTACT INFORMATION

Phone Numbers:	<input type="checkbox"/> Phone (work):	<input type="checkbox"/> Phone (home):	<input type="checkbox"/> Phone (cell / pager):
<b>Check the box next to the number where we can leave a private message that may contain confidential health information</b>			
Name of Spouse or Partner:			
Name(s) of Children:			
Emergency Contact :	home phone:		
Relationship to patient:	work phone:		

### REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	For:
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):			
How did you find Dr. Bowen?	<input type="checkbox"/> Insurance Referral:	<input type="checkbox"/> Physician Referral:	<input type="checkbox"/> Patient Referral: <input type="checkbox"/> Other:
Referring Physician or Patient Name:			
Who is your Primary Care Physician (PCP)?			
Clinic Name, Address and phone:			
Have you ever consulted with or been treated by a naturopathic physician, acupuncturist, chiropractor, nutritionist or massage therapist before?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? Who? (circle those that apply)

### HEALTH CONCERNS (please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes Months?
Is your condition injury or accident related?	<input type="checkbox"/> No <input type="checkbox"/> Yes, auto accident <input type="checkbox"/> Yes, work related
What goals do you have from your visit today and overall?	
What expectations do you have of your physician?	

## MEDICATIONS AND SUPPLEMENTS

<b>Medications &amp; dose:</b>	
1.	4.
2.	5.
3.	6.
<b>Supplements (vitamins, herbs, etc):</b>	
1.	4.
2.	5.
3.	6.

## HEALTH HISTORY / REVIEW OF SYSTEMS

<b>Allergies or Reactions to:</b>				
<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin / antibiotics	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local anesthetics	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Nuts	<input type="checkbox"/> Scents	<input type="checkbox"/> Other:	
<b>History of serious illness, accidents, hospitalization or operations (description, date):</b>				
<b>Childhood Illnesses:</b>				
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	
<input type="checkbox"/> German measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Other:	
Have you ever been touched in a way that made you uncomfortable without your permission?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been physically or emotionally abused?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have concerns with abuse / violence in your life now?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Please check if you have or have ever had:

Condition	Never	Past	Current	Physician's Notes
<b>1. General</b>				
Weight loss / gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Max weight:                  Min. wt:                  Current Wt:
Fever / Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue / Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heat / Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold Hands and Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sweats / Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. Skin</b>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rashes / Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hair or nail dryness / changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. Head</b>				
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. Eyes</b>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Corrective Lenses / Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Floater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. Ears</b>				
	Never	Past	Current	<b>Physician's Notes (Con't)</b>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Ringing of Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. Nose</b>				
Sinus congestion or infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7. Mouth / Throat</b>				
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cavities / Root canals / toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bitter or Metallic taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. Lungs</b>				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing / Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain / Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough: Persistent or Bloody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. Cardiovascular</b>				
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots in Legs or Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling (Edema) of hands, feet, legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmurs / Arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Circulatory Problems (raynauds, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. Gastrointestinal</b>				
Loss of / Excess Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty or pain with swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indigestion / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gas / Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea (with or without blood?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anal Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood or Mucus in Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Black tarry or "coffee ground" stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol / Lipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. Genitourinary</b>				
	Never	Past	Current	
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Wake to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty holding urine (sneeze / cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease / Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. Musculoskeletal</b>				
Muscle pain / spasm / strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint pain / sprain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis (type: )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Back Problems (type: )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. Endocrine</b>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hormone Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>14. Blood / Lymphatic</b>				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood / Lymph disease or cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>15. Allergic / Immune</b>				
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer / Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune (scleroderma, hashimotos, lupus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever / Asthma / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Environmental / Animal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>16. Neurologic</b>				
Epilepsy / Seizures / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with walking / coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paralysis / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>17. Psychologic</b>				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Sexual Health Information

Are you currently sexually active?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	With:	<input type="checkbox"/> Men	<input type="checkbox"/> Women	<input type="checkbox"/> Both	
Have you been sexually active with:	<input type="checkbox"/> Men	<input type="checkbox"/> Women	<input type="checkbox"/> Prostitute				
<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Both	<input type="checkbox"/> Neither	<input type="checkbox"/> Bisexual	<input type="checkbox"/> IV drug user		
Are you satisfied with your sex life?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you practice safer sex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have need for birth control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes					
Method of birth control currently used				Number of sexual partners this year?			
STDs	<input type="checkbox"/> HIV	<input type="checkbox"/> Herpes	<input type="checkbox"/> HPV/ Warts	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Hepatitis
<b>Notes:</b>							

### Male Health Information

Condition	Never	Past	Current	Physician's Notes
Difficult Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Testicular Pain / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impotence / Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Notes:</b>				

### Female Health Information

Menstrual History				Obstetric History							
Age at first period				Have you ever been pregnant			<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Date last menstrual period began				Age at first pregnancy							
Periods regular?				<input type="checkbox"/> No	<input type="checkbox"/> Yes						
Days between periods				Number of pregnancies							
Length of flow				Number of living children							
Heaviness of flow				Number of miscarriages		When in pregnancy?					
Color of flow				Number of tubal pregnancies							
Clots (size? Sm, Med, Lg)				<input type="checkbox"/> No	<input type="checkbox"/> Yes						
Pain with ovulation?				<input type="checkbox"/> No	<input type="checkbox"/> Yes						
Pain with Menses?				<input type="checkbox"/> No	<input type="checkbox"/> Yes						
Menopause?				<input type="checkbox"/> No	<input type="checkbox"/> Yes						
<b>PMS Symptoms:</b>				Difficulty conceiving				<input type="checkbox"/> No	<input type="checkbox"/> Yes		
<input type="checkbox"/> None				<input type="checkbox"/> Bloating/swelling				Difficulty with pregnancy		<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Breast Tenderness				<input type="checkbox"/> Acne				Difficulty with labor or delivery		<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Digestive changes				<input type="checkbox"/> Mood Swings				Difficulty with breast feeding		<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Fatigue				<input type="checkbox"/> Headache				Future OB plans		<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Other											
<b>Vaginitis Symptoms:</b>				<b>Never</b>	<b>Past</b>	<b>Current</b>	<b>Risk Factors</b>				
Discharge				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Abnormal paps		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Irritation				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did your mother take DES?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Itching				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did your mother ever miscarry?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Odor				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you do self breast exams?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Pain with sex				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long term Hormone Replacement?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Trichomoniasis				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Bacteria (BV)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Yeast				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<b>Notes:</b>											

## Family History

Mother:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause	Age:
Father:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	
<b>Has any family member had:</b>	<b>Yes</b>	<b>Which Relative(s) &amp; Age of Onset</b>	<b>Physician's Notes</b>	
Diabetes	<input type="checkbox"/>			
Severe allergies	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>			
Blood clots in lungs or legs	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>			
Kidney Disease	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>			
Thyroid problems	<input type="checkbox"/>			
Colitis / Crohn's	<input type="checkbox"/>			
HIV / AIDS	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>			
Birth Defects	<input type="checkbox"/>			
Drinking or Drug problems	<input type="checkbox"/>			
Breast Cancer	<input type="checkbox"/>			
Colon Cancer	<input type="checkbox"/>			
Ovarian Cancer	<input type="checkbox"/>			
Uterine Cancer	<input type="checkbox"/>			
Other Cancer:	<input type="checkbox"/>			
Mental Illness/Depression	<input type="checkbox"/>			
Alzheimer's	<input type="checkbox"/>			
Other:	<input type="checkbox"/>			
	<input type="checkbox"/>			

## Social & Lifestyle

Habits	Yes	No	Details	Notes
Current Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Past Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:	
Quit?	<input type="checkbox"/>	<input type="checkbox"/>	When?	
Alcohol consumption Types:	<input type="checkbox"/>	<input type="checkbox"/>	Per day? Per week?	
Recreational Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	Type:	
Ever been treated for drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	When?	
Seat Belt Use	<input type="checkbox"/>	<input type="checkbox"/>		
Caffeine Use (coffee, tea, cola)	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day? Type?	
Regular Exercise? Types:	<input type="checkbox"/>	<input type="checkbox"/>	How much?	
Health Hazards at home / work?	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Social</b>				
Happy with relationship status?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have a good support network of family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	Who?	
What is your predominant emotion?				
<b>Lifestyle</b>				
Do you enjoy your work?	<input type="checkbox"/>	<input type="checkbox"/>	Hours per week:	
Stress Level	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	
Stress source	<input type="checkbox"/> Money	<input type="checkbox"/> Job	<input type="checkbox"/> Family/ Relationship	
What do you do to relieve stress?				

Sleep	Yes	No	Details	
Problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>		
Problems staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you wake during the night?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you wake rested in the am?	<input type="checkbox"/>	<input type="checkbox"/>		
Usual bed time / rising time:			Hours of sleep daily:	
Dreams?				
<b>Diet</b>				
Do you follow a particular Diet?				
Known food allergies / intolerances?				
What is a typical breakfast for you?				
Typical Lunch?				
Typical Dinner?				
Snacks?		Dessert / Treats?		
How much water do you drink per day?				

**EXAM AND IMAGING HISTORY (Indicate date, doctor's name or place of most recent)**

Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Colonoscopy		STD screen	
Prostate check		Cholesterol screen	
TB test		Bone density check	

**IMMUNIZATION HISTORY**

Immunization	Date	Boosters
Tetanus – Diphtheria		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu shot		
Other:		

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Physician*

\_\_\_\_\_  
*Date reviewed with patient*