PATIENT HISTORY PROFILE

Patient Name: _____

Address: _____

Phone #: _____ Cell #: _____

E-mail: _____

Health Card Number: _____

Date of Birth: Year _____ Month _____ Day _____ Age _____

Family Doctor: _____ Doctor's Phone Number: _____

Doctor's Fax: _____ Doctor's E-mail: _____

Height: _____ BMI: _____ Waist: _____

	Yes/No	
Reg. Exercise	( ) ( )	
Drugs	( ) ( )	
Smoking	( ) ( )	
Alcohol	( ) ( )	**Date:**
Last Physical	( ) ( )	_____
PAP/PSA	( ) ( )	_____
Mammogram	( ) ( )	_____
Bone Scan	( ) ( )	_____

PAST HISTORY/RISK FACTORS:

Have you ever had or do you have?

	Yes	No
High blood pressure	( )	( )
Diabetes	( )	( )
High cholesterol	( )	( )
Heart disease/heart murmur	( )	( )
Thyroid problems	( )	( )
Kidney disease	( )	( )
Liver disease/hepatitis	( )	( )
Gout/high uric acid	( )	( )
Anemia	( )	( )
Blood transfusions	( )	( )
GI problems/ulcer/abdominal disease	( )	( )
Respiratory problems/asthma	( )	( )
Sleep Apnea	( )	( )
Skin disease	( )	( )
Headaches/migraines	( )	( )
Muscoskeletal	( )	( )
Osteoporosis	( )	( )
Rheumatoid	( )	( )
Chronic fatigue/FMR	( )	( )
Hormonal problems	( )	( )
Psychiatric problems	( )	( )
Epilepsy	( )	( )
Chest pain	( )	( )
Shortness of breath	( )	( )
Recent cough/cold	( )	( )

Please list previous operations and/or any ongoing medical problems, as well as dates if known:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Occupation: _____

Hobbies: _____

Special dietary needs: _____

Allergies: _____

Previous diets: _____

LONG-TERM TREATMENT REGIMEN:

Please list all the medications you are currently taking

(including recent aspirin/tylenol, blood thinners, birth control pills, blood pressure pills, diabetes medications, tranquilizers, steroids/cortisone, heart pills), as well as any reactions you had:

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

Weight loss goal: _____

Personal goal: _____

_____

Please List the Major Illnesses in Close Family Members (e.g. diabetes, heart disease, high blood pressure, thyroid, cancer, kidney, liver, cholesterol, obesity, etc.):

Father: _____

Mother: _____

Brother/Sister: _____

Grandparents: _____

Children: _____