

Mosaic Natural Health Clinic

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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 your practitioner.

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):
Check the box next to the number where we can leave a private message that may contain confidential health information			
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. Andrews? <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?	

Patient Name	Date of Birth:
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MEDICATIONS AND SUPPLEMENTS

Medications & dose:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc):	
1.	4.
2.	5.
3.	6.

HEALTH HISTORY / REVIEW OF SYSTEMS

Allergies or Reactions to:	<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:
History of serious illness, accidents, hospitalization or operations (description, date):				
Childhood Illnesses:				
	<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
1. General				
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"/>	
2. Skin				
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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"/>	
3. Head				
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Eyes				
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"/>	

Patient Name	Date of Birth:
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Floaters	<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"/>	

Patient Name	Date of Birth:
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5. Ears	Never	Past	Current	Physician's Notes (Con't)
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"/>	
6. Nose				
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"/>	
7. Mouth / Throat				
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"/>	
8. Lungs				
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"/>	
9. Cardiovascular				
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"/>	
10. Gastrointestinal				
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"/>	

Patient Name	Date of Birth:
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11. Genitourinary	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"/>	
12. Musculoskeletal				
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"/>	
13. Endocrine				
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"/>	
14. Blood / Lymphatic				
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"/>	
15. Allergic / Immune				
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"/>	
16. Neurologic				
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"/>	
17. Psychologic				
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"/>	

Patient Name	Date of Birth:
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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"/> Both	<input type="checkbox"/> Neither			
<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Prostitute	<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
Notes:							

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"/>	
Notes:				

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	Number of pregnancies
Days between periods	Number of living children
Length of flow	Number of stillbirths
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	Number of abortions When in pregnancy?
Pain with ovulation? <input type="checkbox"/> No <input type="checkbox"/> Yes	Number of Cesarean sections
Pain with Menses? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last pregnancy
Menopause? <input type="checkbox"/> No <input type="checkbox"/> Yes	Difficulty conceiving <input type="checkbox"/> No <input type="checkbox"/> Yes
	Difficulty with pregnancy <input type="checkbox"/> No <input type="checkbox"/> Yes
PMS Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Bloating/swelling	Difficulty with labor or delivery <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Acne <input type="checkbox"/> Mood Swings	Difficulty with breast feeding <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Digestive changes <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache	Future OB plans <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Other	
Vaginitis Symptoms:	Risk Factors
Discharge <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	History of Abnormal paps <input type="checkbox"/> No <input type="checkbox"/> Yes
Irritation / Itching <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Did your mother take DES? <input type="checkbox"/> No <input type="checkbox"/> Yes
Vaginal dryness <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Did your mother ever miscarry? <input type="checkbox"/> No <input type="checkbox"/> Yes
Odor <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Do you do self breast exams? <input type="checkbox"/> No <input type="checkbox"/> Yes
Pain with sex <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Long term Hormone Replacement? <input type="checkbox"/> No <input type="checkbox"/> Yes
Trichomoniasis <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	
Bacteria (BV) <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	
Yeast <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	
Notes:	

Patient Name	Date of Birth:
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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:	
Has any family member had:				
	Yes	Which Relative(s) & Age of Onset		Physician's Notes
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	<input type="checkbox"/>	<input type="checkbox"/>	Per day?	
Types:			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?	<input type="checkbox"/>	<input type="checkbox"/>	How much?	
Types:				
Health Hazards at home / work?	<input type="checkbox"/>	<input type="checkbox"/>		
Social				
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?				
Lifestyle				
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 relive stress?				

Patient Name	Date of Birth:
---------------------	-----------------------

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 rested in the am?	<input type="checkbox"/>	<input type="checkbox"/>		
Usual bed time / rising time:			Hours of sleep daily:	
Dreams?				
Diet				
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