Patient Profile

Date ______________

Patient Name ____________________________________ Date of Birth ______________
Home Address ____________________________________ Sex ______________
City ____________________ State ______________ Zip Code ______________
Home Phone (________)____________________ Work Phone (________)______________
Phone (________) ____________________ Email ______________________
Employer/Occupation ____________________________________
Work Address ____________________________________
City ____________________ State ______________ Zip Code ______________
In Case of Emergency Contact ____________________________________
Contact Phone Number ____________________________________
Relationship To You ____________________________________

Health History

Have You Had or Do You Currently Have?

_________ High Blood Pressure
_________ Chest Pain/Angina
_________ Heart Attack(s)
_________ Irregular Heart Beat
_________ Cardiac Pacemaker
_________ Are you on Dialysis?
_________ Stomach Ulcers
_________ History of Breast Cancer
_________ History of Uterine Cancer
_________ History of Ovarian Cancer
_________ History of Prostate Cancer
_________ Low Sex Drive
_________ Blood Disorder Such as Anemia
_________ Bruise Easily
_________ Gallbladder Trouble
_________ Fainting Spells
_________ Thyroid Trouble
_________ Diabetes
_________ Low Blood Sugar
_________ Swollen Ankles, Arthritis, or Joint Disease
_________ Sleep apnea
_________ Insomnia or Poor Sleep Quality

Are You Currently Taking?

_________ Blood Thinners
_________ Sleep-Inducing Medications
_________ Cortisone
_________ Medications for Acid Reflux or GERD
_________ Thyroid Meds
_________ Antibiotics
_________ Prescription Appetite Suppressants
(Adipex, phentermine, etc.)
_________ Blood pressure meds
_________ Aspirin
_________ Ibuprofen or Tylenol
_________ Antihistamines/Decongestants
_________ Muscle Relaxants or Tranquilizers
_________ Insulin or Diabetic Meds
_________ Antidepressants or Anxiety Medications

Are You Allergic To or Have You Had a Reaction To?

_________ Local Anesthetics _________ Penicillin _________ Codeine or Other Narcotics

_________ Aspirin _________ Other Antibiotics _________ Latex

_________ Any other drug allergies? ____

Women

Could you possibly be pregnant? _________

Are you currently on birth control? _________

Number of Pregnancies? ________________

Date of your last menstrual period ________________

Date of your last pap smear______________________

Date of your last mammogram ___________________

Men

Date of your last prostate exam ____________

Date of your last PSA test _______________________

Both

Current Height _____________ Current Weight ______________

Do you consider yourself in good health? _____Yes _____ No

Any change in your health in the past year? _____Yes _____ No

Are you under the care of a physician? _____Yes _____ No

Have you ever been hospitalized? If so, please list dates and reason for your hospitalization

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Current Meds/Supplements	Strength	Dose/Comments

I certify that I have read and understand the questions on this form. I acknowledge that I will have the opportunity to discuss my health history with my doctor. I will not hold my doctor or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I have received the appropriate Patient Informed Consents and give my permission for treatment.

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Signature **Date**