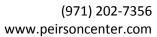


Adult Health History Form

Name		Age Date o	f birth				
Address:	City:	State:	Zip:				
Phone number:	E-mail:	-mail:					
Occupation:							
Emergency contact:	Phone number:						
Biggest concerns and symptoms to address:							
When, where and by who did you last receive med	dical health care?						
If you have one, who is your Primary Care Physicia	n?						
List all drugs, herbs and supplements used here:							
Name	Dose	Frequency	Duration				
		_					
		_	_				
		-					
		_					
Are you allergic to any medications or other substa	ances? □ Y □N	T (f					
Allergy		Type of reactio	n				
			_				
Hospitalizations or surgeries?							
Reason	Dat	e	Hospital				





Health His	story						
Never	Past	Now	Hypothyroidism Hyperthyroidism Anemia Constipation Cancer Heart murmur Eczema	Never	Past	Now	PCOS Depression/Anxiety Sleep Apnea Autoimmune Disease Miscarriage (#:) Irregular periods Headaches
Family His	story						
Never	Past	Now	Hypothyroidism Hyperthyroidism Anemia Mental Illness Cancer Heart disease High blood pressure	Never	Past	Now	Autoimmune disease Stroke Osteoporosis Birth Defects Miscarriage/Infertility Obesity Diabetes
Describe a	a typical c	lay's diet:	:				
Breakfast	:						
Lunch:							
Dinner:							
Snacks:							
Beverages	s:						
Social His							
Do you ex	ercise? \square	Y 🗆 N	If so, in what form and how	w often?			
Do you sm	oke? □ci	garettes	□marijuana □neither				
Do you dri	nk alcoholî	? 🗆 Y 🗆 I	N What form?	How m	uch?		How often?
Marital sta	tus:	□Sing	le \square Married \square	Co-habitate		In a relatio	onship