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Health Summary

Please bring all your medications and supplements at the time of your first visit.
Patient's name (please print):_____D.O.B_____
Today's Date:_____Age:_____Marital Status:_____
Date of last Physical:_____Height_____Weight_____
Reason for visit:_____Occupation:_____
Background: ◊ Ashkenazi ◊ Asian ◊ Mediterranean ◊ Middle Eastern ◊ European
◊ Southeast Asian ◊ African ◊ Native American ◊ Other_____
Name/Address/Phone of Pharmacy:_____

Personal Medical History

◊Heart Disease/Murmur/Angina
◊High Cholesterol
◊High Blood Pressure
◊Low Blood Pressure
◊Leg edema/ Swelling
◊Heart Burn/ GERD
◊Skin Problems
◊Anemia
◊Arthritis
◊Back Pain
◊Autoimmune Diseases
◊Stroke
◊Kidney Disease
◊Cancer type:_____

◊Blood Disorders
◊Chemical Dependency/Alcohol
◊Diabetes
◊Urinary Tract Infections
◊Vaginal Discharge
◊Fibroids
◊Liver Problems
◊Hepatitis
◊STD
◊HIV
◊Seizures
◊ Headache/ Migraines
◊Ulcers/Colitis/IBD
◊Diverticular Disease

◊Prostate Problems
◊Asthma
◊Bronchitis
◊Lung Problems/ COPD
◊Sinus
◊Seasonal Allergies
◊Tonsillitis
◊Ear Problems
◊Eye Problems:
Glaucoma/Cataracts
◊Neurological Problems
◊Depression ◊Anxiety
◊Psychiatric Care
◊Hypothyroidism ◊Hyper
◊Kidney Disorders

Past Surgeries, Traumas, Accidents or Hospitalizations

1.
2.
3.
4.
5.
6.
7.
8.

Vaccines (Please indicate date(s) of administration):

◊ TDAP _____
◊ Hepatitis B _____
◊ COVID-19 _____
◊ Shingrix _____
◊ Pneumovax _____
◊ Influenza_____

Allergies:

Medication Allergies-

Food-

Environmental/Other-

Do you have difficulty tolerating herbs? ◊Yes ◊No ◊Unknown

Current Medications: Please list **ALL** meds that you are currently taking and include dosage and how often you take each medication.

Medication: Dose per day

1.
2.
3.
4.
5.
6.
7.

Current Nutritional Supplements and/or Herbs: Dose per day

1.
2.
3.
4.
5.
6.

Family Medical Conditions:

(Please check and list age of diagnosis)

	Father	Mother	Grandparent(s)	Sibling(s)	Aunt/Uncle	Children
Cancer (type)						
High Cholesterol						
Heart Disease (CAD)						
High Blood Pressure						
Stroke						
Diabetes						
Osteoporosis/Penia						
Arthritis, Gout						
Kidney Disease						
Tuberculosis						
Thyroid Disease						
Asthma						

Chemical Dependency						
Depression						
Neurological Diseases (Parkinsons,Alzheimers)						

Health Habits
How often do you exercise?
◊Never ◊Sometimes ◊Daily
Aerobic exercise (hrs per week)_____
Weight training (hours per week)_____
Please describe your exercise routine:_____
(Weight bearing, Aerobic, Yoga, and Pilates)
Have you ever smoked? ◊Yes ◊No Number of years____
If Current Smoker, how many packs daily _____
Use of smokeless tobacco ◊Yes ◊No

Have you ever used street drugs?
If yes, what kind and how much_____
Caffeine? ◊Yes ◊No
If yes, how much and how often?_____
Stress? ◊Yes ◊No
Alcohol? ◊Yes ◊No
If yes, how much and how often?_____
Do you take time for any hobbies? If so, which ones?
Who lives with you?_____
Do you have pets?_____

REVIEW OF SYMPTOMS: *Are you **Currently** experiencing any of the following?*
Please check ALL boxes that apply.

Constitutional
◊Good health lately ◊Fevers ◊Chills ◊Recent weight loss ◊Recent weight gain ◊Fatigue ◊Sweats
Allergies ◊Watery eyes ◊Itchy nose, eyes, or roof of mouth ◊Sneezing ◊Hay fever ◊Hives ◊Runny Nose
Eyes ◊Wear glasses/Contacts ◊Glaucoma ◊Blurred Vision ◊Double vision ◊Flashers/Floaters

Sleep ◊Snoring ◊Stop breathing at night ◊ Wake up gasping for air at night ◊Dry Mouth ◊Wake up with headaches ◊Often tired during the day/while driving ◊Often fall asleep while reading/ watching TV ◊Difficulty falling asleep or loss of sleep

Skin ◊Rash ◊Itching
◊Change in skin color
◊Change in shape/size of mole
◊Non-healing Sores
Ear, Nose &Throat ◊Hearing loss
◊Ringing in ears ◊Earaches
◊Ear discharge ◊Sinus problems ◊Nose bleeds
◊Sore throat ◊Voice hoarseness
◊Difficulty swallowing
◊Persistent cough

Respiratory ◊Shortness of breath
◊Coughing up blood ◊Wheezing
◊Frequent Cough
Hematologic ◊Easy bleeding/bruising
◊History of Anemia ◊Bleeding gums
◊Enlarged glands ◊History of blood transfusion ◊Slow healing after a cut
Genitourinary ◊Frequent urination
◊Burning or painful urination ◊Blood in urine ◊Change in force of stream
◊Dribbling or incontinence ◊Urinary urgency or hesitancy ◊History of kidney stones ◊Sexual difficulty
Endocrine ◊Excessive thirst/urination
◊History of diabetes ◊Heat or cold intolerance ◊Thyroid problems
Neurological ◊Frequent or recurrent headaches ◊Lightheadedness ◊Fainting
◊Dizziness ◊Numbness ◊Tingling
◊Weakness in extremities ◊History of Seizures ◊Forgetfulness
Psychiatric ◊Depression ◊Anxiety
◊Nervousness ◊Memory loss
Musculoskeletal ◊Joint pains ◊Joint swelling ◊Joint stiffness ◊Back pain
◊Muscle pain/cramps
Female only ◊History of Abnormal PAP
◊Bleeding in between periods ◊PMS
◊Breast lumps ◊Nipple discharge
◊Menstrual pain ◊Hot flashes ◊Vaginal discharge ◊Painful intercourse ◊Mood swings ◊Vaginal dryness

Gastrointestinal ◊Loss of appetite
◊Change in bowel movements ◊Blood in Stool ◊Stomach pain ◊Hemorrhoids
◊Nausea ◊Vomiting ◊Vomiting blood
◊Diarrhea ◊Heartburn/Indigestion
◊Bloating ◊Constipation
Cardiovascular
◊Chest pain
◊ Palpitations/Fast heartbeat ◊Trouble lying flat
◊ Swelling of ankles/legs
◊ Irregular heart beat ◊High blood pressure ◊Low Blood pressure ◊Varicose veins ◊Poor circulation

Menstrual Information
Menopause age____
Age of start of menstruation____
Date of last menstrual period _____
Cycles are generally ◊Regular ◊irregular
Average # of days between periods
Average # days of bleeding _____
◊Heavy ◊Moderate ◊Light
Date of last pap-smear_____
result_____

If applicable:
Are you pregnant or planning to be pregnant soon? Y or N
If pregnant, are you currently breastfeeding? Y or N
Number of Pregnancies_____
living children#____
Number of normal vaginal deliveries_____c-section_____
Number of Miscarriages___Abortions____
Any complications during your pregnancy or childbirth?_____
Did you breastfeed your children?_____if so, how long?____
Current form of Birth Control if applicable_____
Date of last Mammogram_____
result_____
Have you ever been on HRT (Hormone replacement therapy)?_____

Males Only
Last PSA____Frequent urination at night ◊Lump in testicle ◊Penile discharge
◊Erection difficulties ◊Sore on Penis