

PATIENT INFORMATION

Name: _____ Date of Birth _____.

Address: _____ City: _____ State: _____ zip: _____

Phone: H: _____ Wk: _____ Cell: _____

Email Address (please print) : _____

Male Female No. of Children: _____ Occupation: _____ Married

Single Divorced Widow

Employer: _____ Address: _____

Name of Spouse: _____

Person Responsible for account: _____

EMAIL ADDRESS:

INSURANCE INFORMATION

(Please give copy of insurance card to receptionist.)

PATIENTS NAME: _____

Insured's Name: _____ DOB: _____ SEX: _____

Insured's Address: _____

Employer's Name: _____

MAY RELEASE PROTECTED HEALTH INFORMATION

TO:(names): _____

Referred by: _____

NAME: _____

PRIMARY REASON FOR VISIT: _____

Healthy Lifestyle:

Do you smoke cigarettes or cigars? ____ How many per day? ____
Do you drink alcohol? Never ____ Occasionally ____ Every Week ____ More than 2x's week ____ Daily ____
Do you use any other drugs? (type and frequency) ____
Do you exercise? ____ If so, what and how often: ____

Family Medical History (mother, father, siblings, or maternal or paternal grandparents)

Heart Disease ____	Diabetes ____	Bowel Dis. (type) ____
High Blood Pressure ____	Obesity ____	Kidney Dis. ____
Stroke ____	Arthritis (type) ____	Blood Disorder ____
Cancer (type) ____	Psychiatric Dis. ____	Neurologic Dis. ____
Genetic Disease ____	Parental Drug Abuse ____	Sinus Problems ____

SYMPTOM SURVEY: METABOLIC SCREENING QUESTIONNAIRE

POINT SCALE: 1=MILD 2=MODERATE 3=SEVERE

HEAD

Headaches ____
Faintness ____
Dizziness ____
Insomnia ____
Sinus Problem ____

SKIN

Acne ____
Hives, rash, dry skin ____
Hair loss ____
Flushing, hot flashes ____
Excessive Sweating ____

EYES

Watery or Itchy ____
Swollen, red, sticky ____
Bags, dark circles ____
Blurred ____
Tunnel Vision ____

MOUTH/THROAT

Chronic Coughing ____
Gagging, freq. Clearing ____
Sore Throat ____
Hoarseness ____
Sinus Congestion ____

EARS

Itchy Ears ____
Earaches, Ear Infection ____
Drainage from ear ____
Ringing in Ears ____
Hearing Loss ____

ENERGY & ACTIVITY

Sluggishness ____
Apathy ____ Lethargy ____
Restlessness ____
Hyperactivity ____
Fatigue ____

HEART

Irregular Heartbeat ____
Skipped Heartbeat ____
Rapid or pounding HB ____
Chest Pain ____

MIND

Poor Memory __ Confusion __
Learning Disabilities ____
Poor Comprehension ____
Poor Phys. Coordination ____
Difficulty wt Decisions ____

LUNGS

Chest Congestion ____
Asthma, Bronchitis ____
Difficulty breathing ____

DIGESTIVE TRACT

Diarrhea ____
Constipation ____
Bloating feeling ____
Heartburn ____
Intestinal/Stomach pain ____

EMOTIONS

Mood Swings ____
Anxiety, fear, nervous ____
Anger, irritability ____
Aggressiveness ____
Depression ____

JOINTS/ MUSCLE

Pain/ Aches in Joints ____
Arthritis ____
Stiffness ____
Limitation of movement ____
Pain/ Aches in Muscles ____
Weakness or Tired ____

BREAST HEALTH

Fibrocystic _____
Other _____

WEIGHT

Binge eating _____
Binge drinking _____
Food Cravings _____
Excessive Weight _____
Water Retention _____
Underweight _____

OTHER

Frequent Illness _____
Frequent Urination _____
Genital itch _____
Genital Discharge _____

PATIENT MEDICAL HISTORY:

CARDIOVASCULAR

High blood pressure _____
Angina _____
Arythmia _____
Heart Attack _____
Bypass _____
Angioplasty _____
Congestive Heart Failure _____
Pulmonary Edema _____

GASTROINTESTINAL

Ulcer _____
Irritable Bowel _____
Colitis _____
Gallstones _____
Hemorrhoid _____
Hemoptitis _____
Liver Disease _____

PULMONARY

Asthma _____
Pneumonia _____
Emphysema _____
C.O.P.D. _____
Lung Embolus _____
Chronic Bronchitis _____

ENDOCRINE

Diabetes _____
Hypoglycemia _____
Hypothyroid _____
Hyperthyroid _____

UROLOGIC

Kidney Stones _____
Blood in Urine _____
Cystitis _____
Prostatitis _____
Renal(kidney) failure _____
Sexually trans disease _____

NEUROLOGIC

Seizure _____
Multiple Sclerosis _____
ADD/ADHD _____
T.I.A. _____
Other _____

MUSCULOSKETAL

Arthritis _____
Rheumatoid Arth _____
Gout _____
Bursitis _____
Spine _____
Disc disease _____

FEMALES

PMS _____
Menopausal Syndrom _____
Irregular Menstrual Cycle _____
Infertility _____

MEDICATION ALLERGIES: _____

MEDICATION PRESENTLY TAKING: _____

HOSPITALIZATION & SURGERIES: _____