General Patient Information

Please fill in the form below

Patient Name *

Patient Gender *

Male or Female

Birth Date *

Day Month Year

Patient Height (cm) *

Patient Weight (kg) *

Patient E-Mail *

Reason for seeing the doctor: *

Patient Medical History

Please list any drug allergies

Have you ever had (Please check all that apply)

- [ ] Anemia
- [ ] Arthritis
- [ ] Gout
- [ ] Emotional Disorder
- [ ] Fainting Spells
- [ ] Heart Disease
- [ ] Rheumatic Fever
- [ ] Digestive Problems
- [ ] Ulcer Disease
- [ ] Kidney Disease
- [ ] Sleep Apnea
- [ ] Thyroid Problems
- [ ] Venereal Disease
- [ ] Bleeding Disorders
- [ ] Emphysema
- [ ] Asthma
- [ ] Cancer
- [ ] Diabetes
- [ ] Epilepsy Seizures
- [ ] Gallstones
- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] Ulcerative Colitis
- [ ] Hepatitis
- [ ] Liver Disease
- [ ] Use a C-PAP machine
- [ ] Tuberculosis
- [ ] Neurological Disorders
- [ ] Lung Disease

Other illnesses:

Please list any Operations and Dates of Each

Please list your Current Medications

Healthy & Unhealthy Habits

Exercise

- ○ Never
- ○ 1-2 days
- ○ 3-4 days
- ○ 5+ days

Eating following a diet

- ◯ I have a loose diet
- ◯ I have a strict diet
- ◯ I don't have a diet plan

Alcohol Consumption

- ◯ I don't drink
- ◯ 1-2 glasses/day
- ◯ 3-4 glasses/day
- ◯ 5+ glasses/day

Caffeine Consumption

- ◯ I don't use caffeine
- ◯ 1-2 cups/day
- ◯ 3-4 cups/day
- ◯ 5+ cups/day

Do you smoke?

- ◯ No
- ◯ 0-1 pack/day
- ◯ 1-2 packs/day
- ◯ 2+ packs/day

Include other comments regarding your Medical History

Signature *

Clear