PERSONAL HISTORY

TODAY'S DATE:_____/_____/_____

REFERRED BY:_____

LAST NAME:_____ FIRST:_____

SS#:_____ BIRTHDATE:_____AGE:_____

HEIGHT_____WEIGHT: _____

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHYSICAL ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME #:_____CELL #:_____

OCCUPATION:_____WORK #:_____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: NAME:_____PH_____

FATHERS PRESENT HEALTH OR CAUSE OF DEATH:_____

_____

MOTHERS PRESENT HEALTH OR CAUSE OF DEATH:_____

_____

MARK *M* AND/OR *F* FOR ILLNESSES WHICH HAVE OCCURRED IN YOUR BLOOD RELATIVES THAT CORRESPOND TO MOTHER AND/OR FATHERS SIDE:

_____DIABETES _____ALCOHOLISM _____OBESITY

_____CANCER _____MENTAL ILLNESS _____ANXIETY

_____HEART DISEASE _____STROKE _____HIGH BLOOD PRESSURE

____BLOOD DISORDERS ____HIGH CHOLESTEROL___ORGAN DISORDERS

OTHER _____

PLEASE CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE NOW OR HAD IN THE PAST:

☐ DIABETES	☐ ALCOHOLISM	☐ OBESITY
☐ CANCER	☐ MENTAL ILLNESS	☐ ANXIETY
☐ HEART PROBLEMS	☐ STROKE	☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE	☐ TUBERCULOSIS	☐ EYE PROBLEMS
☐ STD/HIV	☐ HIGH FEVERS	☐ ASTHMA
☐ JAUNDICE	☐ ORGAN PROBLEMS	☐ PNEUMONIA
☐ ALLERGIES	☐ HEPATITIS	☐ CHRONIC FATIGUE
☐ ANTIBIOTIC USE	☐ MEASLES	☐ CHICKEN POX
☐ HIGH CHOLESTEROL	☐ SEVERE FATIGUE	☐ FIBROMYALGIA

OTHER:_____

LIST ANY ILLNESSES REQUIRING SURGERY OR HOSPITALIZATION:_____

_____

_____

LIST ANY TRAUMA:_____

_____

LIST ANY KNOWN ALLERGIES:_____

_____

PLEASE LIST THE RESULTS AND DATES OF THE FOLLOWING EXAMS THAT PERTAIN TO YOU:

PHYSICAL:_____

PROSTATE:_____

CHOLESTEROL:_____

PAP SMEAR:_____

MAMMOGRAM:_____

BLOOD TESTS:_____

ARE YOU CURRENTLY PREGNANT: ☐ YES ☐ NO If yes, DUE DATE:_____

THE PURPOSE OF YOUR VISIT:_____

_____

_____

_____