



400 Selby Ave, Suite G2
 St. Paul, MN 55102
 651.224.6678

Patient Health History

Please Fill out the form below as completely as possible

Date: ___/___/___ Name: _____

Date of Birth: ___/___/___ Sex: M / F Marital Status: (circle one) M S W D

Address: _____
(street) (apt #)

(city) (state) (zip)

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ may we include you on our email newsletter? Y / N

Occupation: _____ Employer _____ Hours/Week _____

Emergency Contact: _____
name relationship phone

Primary Physician: _____
name location phone

Please list your major health concerns in order of importance

Complaint	Since	Severity (scale of 1-10, 10=severe)	Other treatments received (Dr. DC, DO, DDS)

Is this condition(s) getting progressively worse?(circle one) Yes No Constant Comes and Goes

Is this condition interfering with your: (circle one) work sleep daily routine other _____

How long has it been since you have felt really good? _____

Do you have a pacemaker or bleeding condition? _____

Do you have any infectious disease ? Y N If yes please identify _____

Please list all known food or drug allergies _____

Please List all medications (prescriptions and over the counter) you are currently taking: _____

Hospitalizations and Surgeries

Reason	When



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Personal History (Please Indicate Self (X), Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF))

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Back pain | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis / IBS | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Food Allergies / Intolerance | <input type="checkbox"/> Gastritis / Pancreatitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hypo/Hyperglycemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Liver/Gallbladder Disease |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Impotence | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | |

Women Only

Age of first menses: _____ Date of last menstrual period: _____ Duration of period: _____
 Length of menstrual cycle: _____ Blood Clots in Flow? Yes No Cramping? Yes No
 Are you/could you be pregnant? Y N If so, how far along are you? _____
 # Pregnancies: _____ # Miscarriages: _____ # Abortions _____

Do you suffer from

- Cramping (Mark as appropriate)
 Severe Moderate Mild
 Before Period After Period During Period
- Clotting
 Bright in Color Dark in Color
- Bleeding Between Periods Endometriosis Mastitis Yeast Infection/Vaginitis
 Infertility Ovarian Cysts Hot Flashes Breast Cysts
- Premenstrual Syndrome
 Fluid Retention Cravings Fluctuating Emotions Irritability Depression
 Fatigue Tenderness in Breasts
- Bleeding / Spotting after menopause

Anything else we should know? _____

How did you hear about us? _____

Signature _____ Date _____