

Name:	Age:	Date:
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Current Medications: None

Medication	Dosage	Frequency	Prescribing Physician

Medical Allergies: None

Medication	What type of reaction?

Personal & Family History:

	Self	Family	Details (Which family member? What was the nature of the problem?)
High Blood Pressure or Vascular Disease (High Cholesterol?, Varicose Veins, Blood clots in legs)			
Heart Disease (Irregular beats, Heart Attack, Valve Problems, etc.)			
Pulmonary Disease (Asthma, Emphysema, COPD, TB, etc.)			
Diabetes (Type 1 or Type 2, Insulin treatment, etc.)			
Thyroid Disease (Underactive, Overactive, Goiters, Graves Disease, etc.)			
Gastrointestinal Diseases (Hepatitis, Gallbladder problems, Acid Reflux, Crohns...)			
Kidney and Bladder Problems (Infections, stones, bladder control problems)			
Neurological Problems (Migraines, Seizures, Strokes, Paralysis)			
Hematologic (Blood) Diseases (Anemia, Leukemia, Clotting Problems, etc.)			
Musculoskeletal Problems (Arthritis, Joint or spine problems, Osteoporosis, etc.)			
Emotional or Psychiatric Problems (PMS< Anxiety, Depression, Bipolar, Suicide, etc.)			
Female Cancers (Breast, Cervix, Uterus, Ovaries)			
Other Cancers (Colon, Lungs, Prostate, etc.)			
Genetic (inherited) or Congenital Diseases (Down Syndrome, Cystic Fibrosis, Hemophilia, etc.)			
Other (Autoimmune Disease such as Lupus, etc.)			

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Any questions, concerns, or problems not covered above? _____

Do you have a Primary Care Provider (Family Practice Physician, Internist, Nurse-Practitioner, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____
Would you like us to send a report and/or test results to your PCP? <input type="checkbox"/> No <input type="checkbox"/> Yes