Hello! In order to be government-compliant for the Electronic Health Records (EHR) requirement, we need all of our patients to fill this out completely.

---Thank you, and if you have any questions, please ask!

Today's Date: _____ Your Full Name: _____

Medications: (Vitamins and herbs come on the next page)

_____ I am not taking any medications at this time (Excellent - good for you!)

List current medications including dosage and how often you take it (daily, twice daily, etc). Also, we need to know how long you have been taking it (approximately --- like 6 months, or 3 years, best you can recall)

--example--- Xanax, 1mg, once a day in the morning, for 2 years

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

(If you need more room, please use the back. Thank you.)

Vitamins (supplements) and Herbs:

_____ I am not taking any vitamins, supplements, or herbs at this time

Please list current items including dosage, Brand name, how often you take it (daily, twice daily, etc), and do you take it with water or not.

--example--- Vit D, Natures Pure brand, 1000 iU, once a day in the morning, with water

1)_____

2)_____

3)_____

4)_____

5)_____

Allergies:

_____ I am not allergic to anything that I know of
-or- These are the MEDICINES or FOODS I am allergic to: (only need info on those 2 things) :

_____ _____ _____

Has any immediate family member ever had any of the following?

(*Please circle and write family member on line*)

Heart Diseases:

- Angina _____
- Heart Attack _____
- Coronary Artery _____
- Bypasses (other) _____
- High Blood Pressure _____

Diabetes:

- Type 1 _____
- Type 2 _____

Lung issues:

- Asthma _____
- COPD _____
- Emphysema _____
- Pneumonia _____

Stomach/Digestion problems:

- Colon trouble _____
- Irritable Bowel _____
- Acid reflux (GI disorder) _____

Alzheimer's _____

High Cholesterol _____

Osteoporosis _____

Stroke _____

Cancer _____ TYPE or WHERE _____

Has any doctor diagnosed you with Hypertension (high blood pressure) ? ___ Yes ___No

Has any doctor diagnosed you with Diabetes ? ___ Yes ___No

If yes, what kind? Type I or II ?

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes__ No __ Not Sure___

Has any doctor diagnosed you with any type of significant health syndrome presently? Yes__ No__ Not Sure___

If yes, what kind? _____

Have you had an X-ray, CT scan, or MRI of your low back spine in the past 28 days? Yes ____ No ____

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To be performed by clinic staff:
Height:____ ____inches Weight: _____pounds BP: _____/_____ L R Date taken: _____