NEW YOU
Health and Wellness

Date_____

PATIENT MEDICAL HISTORY

Name (Last) _____ **(First)** _____ **(MI)** _____

Email _____

Address _____ **City** _____ **Zip** _____

Home _____ **Cell** _____ **Work** _____

Place of Employment _____ **Occupation** _____

Date of Birth _____ **Age** _____ **Sex: M F**

Medical Problems_____

Medications _____

Are you allergic to anything? _____

(Female) How many pregnancies? _____ **Date of last Cycle?** _____

How did you hear about us? _____

(if referred) By whom?_____

Have you ever had any of the following? (Circle Yes or No)

High Blood Pressure	NO	YES	Pituitary Disorder	NO	YES	Any Other Diseases?
Asthma	NO	YES	Kidney Condition	NO	YES	
Blood Clots	NO	YES	Migraines	NO	YES	
Cancer	NO	YES	Tuberculosis	NO	YES	
Diabetes	NO	YES	Seizures	NO	YES	
Emotional Disorder	NO	YES	Premenstrual Disorder	NO	YES	Previous Surgeries?
Dizziness	NO	YES	Skin Condition	NO	YES	
Gallstones	NO	YES	Prostate Problems	NO	YES	
Gout	NO	YES	Stroke	NO	YES	
Heartburn	NO	YES	High Cholestrol	NO	YES	
Heart Disease	NO	YES	Thyroid Condition	NO	YES	Allergies (food or drug)?
Hepatitis	NO	YES	HIV Positive	NO	YES	
Alcoholism	NO	YES	Tumors	NO	YES	
Anemia	NO	YES	Ulcers	NO	YES	