NAME _____ DATE OF BIRTH_____

MEDICATIONS

Medication Name (include all prescriptions, vitamins & over the counter)	Dose	Frequency	For what?

ALLERGIES/CONTRAINDICTIONS

○ No known allergies

Name	Reaction

MEDICAL HISTORY

Allergies	YES	NO		Depression	YES	NO		Myocardial Infarction	YES	NO
Anemia	YES	NO		Diabetes Mellitus	YES	NO		Nerve/Muscle Disease	YES	NO
Anxiety	YES	NO		Dexa/Bone Density	YES	NO		Osteoporosis	YES	NO
Arthritis	YES	NO		Emphysema	YES	NO		Seizures	YES	NO
Asthma	YES	NO		GERD	YES	NO		Shortness of Breath	YES	NO
Blood Transfusion	YES	NO		Glaucoma	YES	NO		Sickle Cell Anemia	YES	NO
Cancer	YES	NO		Heart Murmur	YES	NO		Stroke	YES	NO
Cataracts	YES	NO		High Cholesterol	YES	NO		Substance Abuse	YES	NO
Chest Pain	YES	NO		HIV/ AIDS	YES	NO		Thyroid Disease	YES	NO
CHF	YES	NO		Hypertension	YES	NO		Tuberculosis	YES	NO
Clotting Disorder	YES	NO		Kidney Disease	YES	NO		Ulcers	YES	NO
COPD	YES	NO		Meningitis	YES	NO		Migraines	YES	NO
Fatigue	YES	NO		Sleep Apnea	YES	NO				

Other Medical History:

_____

SURGICAL HISTORY

AAA Repair	YES	NO		Colon Surgery	YES	NO		Joint Replacement	YES	NO
Appendectomy	YES	NO		Cosmetic Surgery	YES	NO		Intestine Surgery	YES	NO
Brain Surgery	YES	NO		Eye Surgery	YES	NO		Spine Surgery	YES	NO
CABG	YES	NO		Fracture Surgery	YES	NO		Tonsillectomy	YES	NO
Cholecystectomy	YES	NO		Hernia Repair	YES	NO		Tubal ligation	YES	NO
Colon/ Bowel Surgery	YES	NO		Hysterectomy	YES	NO		Valve Replacement	YES	NO
				Vasectomy	YES	NO		Prostate Surgery	YES	NO

Other Surgical History: _____

NAME _____ DATE OF BIRTH_____

FAMILY HISTORY

Relationship	Alive?	Alcohol Abuse	Arthritis	Asthma	Autoimmune disorder	Cancer	COPD	Depression	Diabetes	Drug Abuse	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Stroke	Vision Loss	Other/Comments
Mother	☐Y N☐																		
Father	☐Y N☐																		
Sister 1	☐Y N☐																		
Sister 2	☐Y N☐																		
Sister 3	☐Y N☐																		
Brother 1	☐Y N☐																		
Brother 2	☐Y N☐																		
Brother 3	☐Y N☐																		
Son 1	☐Y N☐																		
Son 2	☐Y N☐																		
Daughter 1	☐Y N☐																		
Daughter 2	☐Y N☐																		
Mat GM	☐Y N☐																		
Mat GF	☐Y N☐																		
Pat GM	☐Y N☐																		
Pat GF	☐Y N☐																		
	☐Y N☐																		
	☐Y N☐																		
	☐Y N☐																		

☐ Adopted ☐ Family History Unknown

Other Family History: _____

_____

_____

ALCOHOL SCREEN

Have you ever had more than 4 drinks in a day? ☐Yes No☐

How many times in the past 12 months? ⓪①②③④⑤+

☐☐☐☐☐☐

SOCIAL HISTORY

Alcohol Use? ☐Yes No☐

Drinks/Week

	Glasses of wine
	Cans of beer
	Shots of liquor
	Drinks containing 0.5oz of alcohol

☐ ☐ ☐

Sexually Active? Yes No Not Currently

Partners ☐Female Male☐

Birth Control/Protection:

☐None

☐Abstinence ☐Coitus Interruptus ☐Condom ☐Diaphragm

☐Implant ☐Injection ☐Inserts ☐IUD

☐OCP ☐Patch ☐Post-menopausal ☐Rhythm

☐Spermicide ☐Sponge ☐Surgical ☐Other-see comments

NAME _____ DATE OF BIRTH_____

Drug Use? ☐ Yes No ☐

Use/week _____ times a week

Type

☐ Amphetamines	☐ Amyl Nitrate	☐ Anabolic Steroids	☐ Barbiturates
☐ Benzodiazepines	☐ "Crack" cocaine	☐ Cocaine	☐ Codeine
☐ Fentanyl	☐ Other	☐ GHB	☐ Hashish
☐ Heroin	☐ Hydrocodone	☐ Hydromorphone	☐ Ketamine
☐ LSD	☐ Marijuana	☐ MDMA (Ecstasy)	☐ Mescaline
☐ Methamphetamines	☐ Methaqualone	☐ Methylphenidate	☐ Morphine
☐ Nitrous Oxide	☐ Opium	☐ Oxycodone	☐ PCP
☐ Psilocybin	☐ Solvent Inhalants	☐ Other- see comments	

Comments:

_____

Tobacco Use? ☐ Yes No ☐

If so, Ready to Quit? ☐ Yes No ☐

○ Smoker, Currently # Packs/day: _____

○ Former Smoker, Previously Quit Date: _____ # Packs/day: _____

○ Smokeless Tobacco, Currently

○ Smokeless Tobacco, Previously Quit Date: _____ # Packs/day: _____

Comments: _____

SOCIOECONOMIC HISTORY

Occupation: _____ ○ Retired

Employer: _____

Spouse Name	
# of Children	
Language	☐English ☐Spanish ☐Chinese ☐French ☐Vietnamese ☐Arabic ☐German ☐Greek ☐Italian ☐Hindi ☐Russian ☐Sign Language ☐Thai ☐Somali ☐Other:_____
Ethnicity	☐Hispanic or Latino ☐Non-Hispanic or Latino
Race	☐Black/African American ☐White/Caucasian ☐Asian ☐American Indian ☐Hawaiian/Pacific Islander ☐Other ☐Refuse to answer

Lives with: _____

HEALTH MAINTENANCE

Please document the date of last completion and results if appropriate for the following:

Screening	Date Completed	Result/Comments
Pap smear / pelvic (women only)		Normal or Abnormal?
Mammogram		Normal or Abnormal?
Colonoscopy		Normal or Abnormal?
DEXA./Bone Density Scan		Normal or Abnormal?
PSA (men only)		Normal or Abnormal?

NAME _____ DATE OF BIRTH_____

VACCINATIONS

	Have you received this vaccine?	Year(s) given
Influenza vaccine	☐Yes ☐No ☐Don't Know	
Hepatitis vaccine	☐Yes ☐No ☐Don't Know	
Pneumonia Vaccine (Pneumovax or Prevnar13)	☐Yes ☐No ☐Don't Know	
Tetanus	☐Yes ☐No ☐Don't Know	
TdaP	☐Yes ☐No ☐Don't Know	
Zoster/shingles vaccine	☐Yes ☐No ☐Don't Know	
HPV vaccine	☐Yes ☐No ☐Don't Know	
BCG (outside U.S.)	☐Yes ☐No ☐Don't Know	

OTHER PROVIDERS

As your Whole Health Practitioner, it is my job to make sure I keep current with your other providers and care teams. Please list names below.

Heart specialist:	OB/GYN:
Digestive specialist:	Neurologist:
Endocrinologist:	Eye Doctor:
Orthopedist:	Pain Management:
Urologist:	Physical/Occ therapist:
Kidney specialist:	Dermatologist:
Counseler:	Cancer specialist:
Other:	

Are you interested in using Nourishly Patient Portal for our nutritional therapy services? ☐ Yes ☐ No

Thank you for taking the time to share your story.
Taking this step toward your health and well-being is a powerful act of self-care, and I honor the courage it takes to begin. I'm here to support you on this journey