Health History Form *MUST be complete to be seen by Dr. Dean*

Name:_____ Today's date:_____

DOB:____/____/_____ Height:_____Weight:_____ Sex:_____Pronouns:_____ Age:_____

1. Have you had a recent (6 mo) physical? Y N Cardiac stress test? Y N Blood Work? Y N Biopsy? Y N
2. Have you had a colonoscopy? (over 45 yo) Y N Results:_____
3. Do you have high: Blood pressure? Y N (>120/80) Cholesterol? (>200) Y N Trigs? (>150) Y N
4. What is your fasting glucose?_____ HbA1c? _____ Are your Diabetic? PRE Type1 Type 2 Since: _____Yr
5. Has your nutrition been assessed? Y N Explain: _____
6. All PRIOR or CURRENT diagnosis by a doctor (Did treatment resolve the complaint? Or, no treatment?)
    1. _____(Mo/Yr)_____
    2. _____(Mo/Yr)_____
    3. _____(Mo/Yr)_____
7. Have you had any surgery, procedures, births (cosmetic/botox/injections/laser/tattoos/piercings)?
    1. _____(Mo/Yr)_____
    2. _____(Mo/Yr)_____
    3. _____(Mo/Yr)_____
    4. Metal implants: _____
8. Do you have any complaints not yet addressed by a physician? Explain:
    1. _____
    2. _____
    3. _____
9. Have you had any accidents, auto collisions, falls, sports injuries, or suspect concussions?
    _____(Year) _____
10. Are you taking medications? Explain: _____
    _____
    Did you take medication in the past? Explain: _____
11. List all types of treatment/health care you received in the past/now:
    1. _____ 4. _____
    2._____ 5. _____
    3._____ 6. _____
12. Does your family's health history concern you? Y N Explain: _____
13. Has a first Degree Relative had a heart attack? Y N Cancer? Y N Diabetes? Y N Stroke? Y N
14. Do you smoke or vape? Y N _____ Drink alcohol? Y N _____
    Edibles? Y N CBD? Y N Caffeine? Y N Other non prescriptions?_____
15. Do you have labored breathing when climbing stairs? Y N Any other time? Y N
16. Do you get dizzy at any time? Y N Lose you balance? Y N Nausea? Y N Vomiting? Y N
17. Do you have numbness, tingling or loss of sensation in your hands or feet? Y N Dexterity Issues? Y N
18. Do you have any lifestyle habits that you believe are contributing to your complaint today?
    _____
19. Do you participate in at least 30 minutes of moderate to vigorous exercise per day? Y N Explain:
    _____
21. Has a doctor recommended exercise and diet change? Explain:
    _____
22. Do you regulate/control your diet? Explain: _____
23. How much sleep/naps do you get?_____ Do you feel it is sufficient and peaceful? Y N
24. Do you take supplements/vitamins? Explain: _____
25. Sources of stress (be very specific):_____
26. Primary complaint for today:_____