

Health History Form

MUST be 100% complete to be seen by Dr. Dean

Name: _____ Today's date: _____

1. Recent physical? Y N Cardiac stress test? Y N Blood Work? Y N Biopsy? Y N X-Ray/MRI/CT? Y N

2. Colonoscopy? Y N Breast Exam? Y N Mammogram? Y N Prostate Exam? Y N Hormone Test? Y N

3. Do you have high: Blood pressure? Y N (>120/80) Cholesterol? (>200) Y N Triglycerides? (>150) Y N

4. Fasting glucose? _____ HbA1c? _____ Diabetic? Y N PRE Type1 Type 2 Since: _____ Yr

5. Has your nutrition been assessed? Y N Explain: _____

6. Food Habits: Very healthy Healthy Average Poor Very poor Omnivore Vegan Vegetarian Keto

7. Vitamins/supplements? Y N : _____

8. Family History: Stroke Heart Attack Digestive Blood Dementia Mental Cancer: _____

9. **Today's complaint:** _____ Started(date): _____

10. Has your complaint already been diagnosed or treated by a physician? Explain _____

11. All **PRIOR or CURRENT** diagnosis by a doctor (Did treatment resolve the complaint? Or, no treatment?)

1. _____ (Yr) _____

2. _____ (Yr) _____

3. _____ (Yr) _____

12. Prior ER visits, surgery, procedures, treatments, therapy? Y N

1. _____ (Mo/Yr) _____

2. _____ (Mo/Yr) _____

3. _____ (Mo/Yr) _____

4. Metal implants: _____ Allergies: _____

13. List all types of professional treatment/health care you received for any problem:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

14. Taking medications (for any reason)? Y N Explain _____

15. Do you smoke or vape? Y N Drink alcohol? Y N Edibles? Y N CBD? Y N Caffeine? Y N

16. Do you have labored breathing? Y N Unexplained tiredness? Y N Unexplained weight loss? Y N

17. Do you get dizzy at any time? Y N Lose you balance? Y N Nausea? Y N Vomiting? Y N

18. Do you participate in at least 30 minutes of moderate to vigorous exercise per day? Y N

Explain: _____

19. How much sleep/naps do you get? _____ Do you feel it is sufficient and peaceful? Y N

20. Sources of stress (be specific): _____