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. Are you taking vitamins/supplements? Y N :_____
7. All **PRIOR or CURRENT** diagnosis by a doctor (Did treatment resolve the complaint? Or, no treatment?)
    1. _____(Yr)_____
    2. _____(Yr)_____
    3. _____(Yr)_____
    4. _____(Yr)_____

8. Prior ER visits, surgery, procedures, treatments, therapy? Y N
    1. _____(Mo/Yr)_____
    2. _____(Mo/Yr)_____
    3. _____(Mo/Yr)_____
    4. Metal implants: _____Allergies:_____

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

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

11. Taking medications (for any reason)? Y N Explain_____

12. List all types of professional treatment/health care you received:
    1. _____ 4. _____
    2._____ 5. _____
    3._____ 6. _____

13. Do you smoke or vape? Y N Drink alcohol? Y N Edibles? Y N CBD? Y N Caffeine? Y N
14. Do you have labored breathing? Y N Unexplained tiredness? Y N Unexplained weight loss? Y N
15. Do you get dizzy at any time? Y N Lose you balance? Y N Nausea? Y N Vomiting? Y N
16. Do you participate in at least 30 minutes of moderate to vigorous exercise per day? Y N
    Explain: _____
17. How much sleep/naps do you get?_____ Do you feel it is sufficient and peaceful? Y N
18. Sources of stress (be specific):_____