Downtown Gilbert Healthcare **New Patient Health History**

Full Name		Birthday	
Street Address			
City		Zip Code	
Email Address		Phone	
Are you recovering from a cold/flu?		Yes / No	
Are you pregnant?		Yes / No	

Reason for office visit (Please include the date the condition began)

Health History

List any health problems or medical diagnoses for which you are currently being treated:

What types of therapies have you tried for these problems or to improve your current medical condition? (check all that apply)

- ☐ Diet
- ☐ Fasting
- ☐ Vitamins / Minerals
- ☐ Herbs
- ☐ Homeopathy
- ☐ Chiropractic and/or Massage
- ☐ Acupuncture
- ☐ Conventional Prescription Medications
- ☐ Other

If you checked "other", please specify:

Primary Care Physician Name:

Primary Care Physician Phone Number:

Laboratory and **Imaging** procedures performed (blood, stool, urine, X-ray, CT, MRI, US, etc.). Please indicate date of labs or imaging:
Major hospitalizations, surgeries, and injuries. Please list all procedures, complications (if any), and dates:
Please rate your level of stress you are experiencing on a scale of 1-10 (1 being the lowest): 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Identify the major cause(s) of stress (eg work, finances, relationship(s), etc.)
What is your overall energy level on a scale of 1-10 (1 being the lowest, 10 the highest): 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Do you consider yourself: (circle one) Underweight — Just right — Overweight

Your weight today:		Wt at age 20	
Your ideal weight:			
Have you had an unintentional weight loss or gain of 10+ pounds or more in the last three months?		Yes / No	
Are you or have you been exposed to potentially harmful chemicals (eg pesticides, solvents, etc)		Yes / No	

If you marked yes, please explain:

Current prescription medications (**please list name, dosage, reason for taking, and when you started**):

Current supplements and vitamins (**please list name, dosage, reason for taking, and when you started**):

List any known environmental and/or food allergies:

List any known drug allergies. Please include what reactions you experience.

How committed are you to making a change in your health? (1 being low commitment, 7 being high)

1 — 2 — 3 — 4 — 5 — 6 — 7

Medical History

Please check the conditions you have experienced in the past (P), or are currently experiencing (C)

☐P	☐C	Arthritis	☐P	☐C	Allergies/Hay Fever
☐P	☐C	Asthma	☐P	☐C	Alcoholism
☐P	☐C	Alzheimer's disease	☐P	☐C	Blood pressure problems
☐P	☐C	Bronchitis	☐P	☐C	Cancer
☐P	☐C	Chronic fatigue syndrome	☐P	☐C	Carpal tunnel syndrome
☐P	☐C	Chest pain	☐P	☐C	Cholesterol, elevated
☐P	☐C	Circulatory problems	☐P	☐C	Dental problems

☐P	☐C	Depression	☐P	☐C	Diabetes, Type 1
☐P	☐C	Diabetes, Type 2	☐P	☐C	Diverticular disease
☐P	☐C	Drug addiction	☐P	☐C	Eating disorders
☐P	☐C	Epilepsy/seizure	☐P	☐C	Emphysema
☐P	☐C	Food intolerance	☐P	☐C	Gastroesophageal reflux disease (GERD)
☐P	☐C	Genetic disorder	☐P	☐C	Glaucoma
☐P	☐C	Gout	☐P	☐C	Heart Disease
☐P	☐C	Infection, chronic	☐P	☐C	IBD/Colitis
☐P	☐C	Irritable bowel syndrome	☐P	☐C	Kidney or bladder disease
☐P	☐C	Liver or gallbladder disease	☐P	☐C	Mental illness
☐P	☐C	Migraine headaches	☐P	☐C	Neurological disease (Parkinson's, paralysis…)
☐P	☐C	Stroke	☐P	☐C	Thyroid problems
☐P	☐C	Obesity	☐P	☐C	Osteoporosis
☐P	☐C	Pneumonia	☐P	☐C	Sexually transmitted illness
☐P	☐C	Skin problems	☐P	☐C	Tuberculosis
☐P	☐C	Ulcer	☐P	☐C	Urinary tract infection
☐P	☐C	Varicose Veins	☐P	☐C	Other

If you checked other, please specify:

Health Habits

Smoke: Yes / No	If yes, how much and for how long?		
Drink alcohol: Yes / No	If yes, how much and for how long?		
Use caffeine: Yes / No	If yes, how much and for how long?		
Hours of sleep per night		Restful sleep?	Yes / No
Number of BMs per day:		Blood in stool?	Yes / No
Consistency of BM:	Hard / Soft / Loose / Marbles / Watery		
Exercise habits	None / 1-2 days per week / 3-4 days per week / 5+ days per week		
	Less than 45 minutes per workout / More than 45 minutes per workout		
Nutrition and diet	Mixed foods (animal and plant protein) / Vegetarian / Vegan		

Medical History (Female). Please check all that apply in the past (P) or currently (C):					
☐P	☐C	Menstrual irregularities	☐P	☐C	Endometriosis
☐P	☐C	Infertility	☐P	☐C	Fibrocystic breasts
☐P	☐C	Fibroid / ovarian cysts	☐P	☐C	PMS (premenstrual syndrome)
☐P	☐C	Breast cancer	☐P	☐C	Pelvic inflammatory disease
☐P	☐C	Vaginal infections	☐P	☐C	Decreased sex drive
☐P	☐C	Menopause	☐P	☐C	C-section
If other, please specify:					

If you have had a c-section, how many have you had?			
Date of last GYN exam:		Last PAP results	Positive / Negative
Last mammogram results	Positive / Negative	Last Thermogram results	Positive / Negative
Number of pregnancies		Number of live births	
Number of abortions			
Age at first menses		Date of last menstrual period	
Length of cycle (in days)			
Any recent changes in menstrual flow? (eg heavier, more clots, changes in pain, etc)			

Medical History (Male). Please check all that apply in the past (P) or currently (C):					
☐P	☐C	Decrease in libido (sex drive)	☐P	☐C	Lack of energy
☐P	☐C	Decrease in strength/endurance	☐P	☐C	Loss of height
☐P	☐C	Decreased "enjoyment of life"	☐P	☐C	Feelings of sadness or grumpy
☐P	☐C	Decreased strength of erections	☐P	☐C	Decreased ability to play sports
☐P	☐C	Falling asleep after dinner	☐P	☐C	Deterioration in work performance
☐P	☐C	Benign prostatic hyperplasia (BPH)	☐P	☐C	Prostate cancer
☐P	☐C	Infertility	☐P	☐C	Other
If other, please specify:					

Family Medical History (Grandparents (G), Parents (P), siblings (S).) Please check all that apply:

☐G	☐P	☐S	Arthritis	☐G	☐P	☐S	Asthma/lung disease
☐G	☐P	☐S	Alcoholism	☐G	☐P	☐S	Alzheimer's disease
☐G	☐P	☐S	Autoimmune disease	☐G	☐P	☐S	Cancer
☐G	☐P	☐S	Depression	☐G	☐P	☐S	Diabetes
☐G	☐P	☐S	Drug addiction	☐G	☐P	☐S	Eating disorder
☐G	☐P	☐S	Genetic disorder	☐G	☐P	☐S	Glaucoma
☐G	☐P	☐S	Heart disease	☐G	☐P	☐S	Hypertension
☐G	☐P	☐S	Infertility	☐G	☐P	☐S	Mental illness
☐G	☐P	☐S	Migraine headaches	☐G	☐P	☐S	Obesity
☐G	☐P	☐S	Osteoporosis	☐G	☐P	☐S	Stroke

If other, please specify:

Is there anything else about your health history we should be aware of?