Preferred name/title: _____Middle Initial: _____

Gender: _____ Social Sec Number: _____

Address: _____

_____

Patient email address: _____

Cell phone: _____ Home phone: _____

Race (affects health risks): _____

☐ Hispanic ☐ not Hispanic

Employment: ☐ Employed ☐ Retired ☐ Homemaker ☐ Disabled ☐ Other

Employer: _____ Work phone: _____

Please circle the preferred phone number for contacts regarding healthcare information.

Who may we thank for referring you?

_____

Marital status: _____ Partner name (last, first): _____

Partner phone number: _____

Emergency contact (not living with you) name: _____

Phone number of emergency contact: _____

Relationship to patient: _____

Medical History: Check the box in *front* of each medical problem you have had:

☐	Asthma	☐	High cholesterol/hyperlipidemia
☐	Blood clots in legs or lungs	☐	Intracranial hypertension
☐	Depression	☐	Migraines
☐	Diabetes Type II	☐	Osteoarthritis/ arthritis
☐	Diabetes Type I	☐	Pickwick syndrome low blood oxygn
☐	Fatty liver/ steatohepatitis/NASH	☐	Polycystic Ovaries/ PCOS/ PCOD
☐	Gallstones or gall bladder disease	☐	Pseudotumor cerebri
☐	GESTATIONAL Diabetes	☐	Sleep apnea (OSA)or sleep disorders
☐	Gout	☐	Urine stress incontinence (leak urine)
☐	Heartburn/ gastroesophageal reflux	☐	Varicose veins/venous stasis disease
☐	High blood pressure/hypertension	☐	Yeast infection in skin folds

☐ Other: _____

_____

Number of pregnancies: _____ Any miscarriages? _____ Irregular periods ? _____

Age at first pregnancy: _____ Age at last pregnancy: _____ Last period: _____

Surgical History: List surgeries that you have had in the past:

Date:	Surgery:

Mental Health: List any mental health conditions that you have had, such as depression, bipolar, schizophrenia, addiction:

_____

_____

Have you ever been a victim of abuse? ☐ yes ☐ no

Additional information:

_____

_____

Allergies: List food and medication allergies:_____

_____

_____

Medications: List all current medications and doses, including vitamins/herbs:

_____

_____

_____

_____

_____

Additional chemical exposure:

Tobacco use? Type & approx amount: _____

Alcohol intake? Type & approx amount: _____

Marijuana/ CBD oil/ cannabis products? Type & approx amount:

_____

Other street drugs or chemicals:

_____

Stress History: How would you describe the stress in your life? 1= low, 5 = high:

_____

How do you cope with stress? _____

Family History: Number of siblings: _____

List family members affected by obesity, high blood pressure, diabetes, sleep apnea, mental health conditions, and cancer

Relation:	Medical condition:

Support Systems:

Who do you live with? _____

Who selects and purchases food? _____

How would you describe your family and friends as a support system?

_____

_____

Do you enjoy learning about health, nutrition, and physical activity? Comments:

_____

_____

Are you comfortable with new technology?

Internet ☐ yes ☐ no Smart phone use ☐ yes ☐ no

Texting ☐ yes ☐ no Using apps to track/organize ☐ yes ☐ no

I prefer to keep ☐ electronic records ☐ paper records

Sleep Apnea Risk Assessment: The following questions evaluate your risk for Sleep Apnea (OSA), a dangerous medical condition in which people stop breathing in their sleep.

On average, how many hours do you sleep per night ? _____

Do you feel rested when you wake up? ☐ yes ☐ no ☐ not sure

Have you had a sleep study? ☐ yes ☐ no ☐ not sure

☐ I have been diagnosed with sleep apnea and my sleep doctor is: _____

☐ I have been tested, but I do not have sleep apnea

Are you likely to fall asleep in these situations?

Situation	No	Slight chance	Moderate chance	High chance
Watching TV	☐	☐	☐	☐
Sitting and reading	☐	☐	☐	☐
Sitting and talking to a person	☐	☐	☐	☐
Sitting inactive in a public place (theater, shop, etc)	☐	☐	☐	☐
Riding in a car, as a passenger, for an hour straight	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
In a car, while stopped in traffic for a few minutes	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐