Patient Health Update

Patient Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Mobile Phone** _____

Home email _____

Your e-mail address will not be used for Spam but will allow you access to an online portal to view your records and allow us to communicate to you personalized health information.

Current medications including frequency and dosage, if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known medication allergies that you have. If no known allergies, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Has any doctor diagnosed you with Hypertension (High Blood Pressure) presently? ❑ Yes ❑ No If yes, describe:

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If **yes**, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Verification Question ***(Choose only one question by checking the question, then give the answer to that question.)***

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
****Answers must be at least 6 characters.****

Social History/Habits:

Sleep _____hours Coffee/Tea _____cups/day Alcohol _____drinks/week Soda _____drinks/day

Water _____glasses/day Exercise _____/week Recreational Drug Use: ____None ____Past ____Present

Physical Stress Level: _____Mild _____Moderate _____High

Emotional Stress Level: _____Mild _____Moderate _____High

Family History:

	Arthritis	Cancer	Diabetes	Heart disease	High blood pressure	Stroke	Psychiatric	Other
Father								
Mother								
Brothers								
Sisters								
Sons								
Daughters								

Date: _____ _____
Patient's Signature

_____
Guardian's Signature

To be performed by clinic staff:

Height: _____inches **Weight:** _____pounds **BMI:** _____ **BP:** _____/_____ **Pulse:** _____