Patient Health History Form

Contact Information

Date _____

Full Name _____ Gender: M / F DOB: _____

Address: _____ City / State / Zip: _____

Phone: _____ (home / cell) Email: _____

Occupation: _____ Work Phone: _____

Emergency contact name: _____ Relationship: _____

Emergency contact phone: _____ Marital: S / M / D / W (please circle)

Primary Care Physician: _____ Phone: _____

How were you referred to Dr. Katie Gregory? _____

Primary Health Concerns

Please list in order of importance

1) _____ Onset: _____

2) _____ Onset: _____

3) _____ Onset: _____

4) _____ Onset: _____

5) _____ Onset: _____

What types of therapies have you tried?

_____ Prescription drugs _____ Vitamins / herbal therapy _____ Acupuncture

_____ Diet modification _____ Homeopathic remedies _____ Chiropractic

Please list any medications you are currently taking, and dosage (include oral contraceptives, OTC allergy and pain relievers)

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any vitamins, supplements, homeopathic or herbal therapies you are currently taking:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

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Past Medical History

Please list any hospitalizations, surgical procedures, dental procedures, major illnesses or injuries:

Date of last physical exam: _____ Date of last blood tests: _____

Recent immunizations? If yes, please list: _____

Do you have any life-threatening allergies? If yes, please list: _____

Do you have any seasonal, environmental, food or chemical allergies / sensitivities? If yes, please list:

Screening Exams	**Date of exam (if applicable)**	**Any abnormal findings?**
Mammogram		
Thermogram		
PAP smear		
Bone density		
Colonoscopy		
PSA		

Additional Information

Are you physically active on a regular basis? Y / N Please describe your exercise / activity regime:

Please describe any dietary restrictions / modifications, if applicable: _____

Do you regularly use any of the following substances? Please indicate frequency of usage / consumption:

Alcohol	_____	Drugs	_____	Soda	_____
Coffee	_____	Cigarettes	_____	Fast food	_____
Tea	_____	Tobacco	_____	Sweets	_____

What are your goals for this visit? _____

What questions do you have? _____

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