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PATIENT INFORMATION

Name *(Last, First, M.I.):*		**Today's Date**	
Address *(Street.):*		**Date of Birth**	
(City, State, Zip.):		**Occupation**	
Email		**Employer**	
Phone	H:	C:	W:
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Children (Names, Ages)			
EMERGENCY CONTACT INFO	**Name** *(Last, First, M.I.):*		
Phone	H:	C:	W:
Relationship to Patient			
Primary Care Physician:		**Physician's Phone Number:**	
How did you hear about Sean?			

MEDICAL HISTORY

Please complete this questionaire as thoroughly as possible. Thank you.

Please comment about your major health and wellbeing concerns in order of importance to you. It will help if you include to what extent they affect your daily life now.

1.		**Date of Onset:**	
2.		**Date of Onset:**	
3.		**Date of Onset:**	
4.		**Date of Onset:**	

When and where did you last receive medical healthcare?	
For what reason?	

Is your condition due to prior medical treatment or a reaction to a medication? If so, please explain.

Medications & Supplements

Please list all prescription medications that you are currently taking, the dosages, and for what conditions they are used:	
Please list all natural supplements that you are currently taking, the dosages, and for what conditions they are used:	

Personal Past & Current Medical History

Please specify diagnosis	Date of Onset	Treatments
Have you undergone a course of antibiotics recently?		

General

Height:		Weight (lbs):		Weight 1 year ago:	
Maximum Weight (lbs):			**When?**		

Hospitalizations, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CT Scans, EEG, EKG have you had?

Procedure	Year	Procedure	Year

Daily Routines

Please describe your daily activities from when you awaken until you goto sleep.
Include a "typical" meal or types of foods you eat, as well as your exercise, work and other activities.

MORNING	Time	Food, Activities, Routines	Variation
Awaken			
Breakfast			
Activities after Breakfast			
MIDDAY	Time	Food, Activities, Routines	Variation
Lunch			
Activities after Lunch			
EVENING	Time	Food, Activities, Routines	Variation
Dinner			
Activities after Dinner			
NIGHT	Time	Food, Activities, Routines	Variation
Activities			
Bed Time			
List other regular activities not included above. These may include exercise, meditation, spiritual practices, etc.			
Water amount in ounces or cups per day:			
Alcohol beverages per week:		Caffeinated beverages per day:	
Dietary restrictions or type of diet:			

Childhood Illnesses

Have you had any of the following childhood illnesses? (mark if yes)

☐ Scarlet Fever	☐ Diphtheria	☐ Rheumatic Fever	☐ Mumps	☐ Measles	☐ Polio

Allergies

Please list if you are hypersensitive or allergic to the following:

Drugs:			
Foods:			
Environmentals or chemicals:			

Family Medical History

Please specify: M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, PGM = paternal grandmother, PGF = paternal grandfather, MGM = maternal grandmother, MGF = maternal grandfather

Cancer		**Diabetes**		**Epilepsy**	
Heart Disease		**High Blood Pressure**		**Stroke**	
Anemia		**Kidney Disease**		**Glaucoma**	
Allergies		**Asthma**		**Mental Illness**	
Arthritis		**Tuberculosis**		**Alzheimer's Disease**	

REVIEW OF SYSTEMS

RESPIRATORY			
☐ Common Colds	☐ Asthma	☐ Wheezing	☐ Difficulty Breathing
☐ Shortness of Breath	☐ Emphysema	☐ Pneumonia	☐ Persistent Cough
☐ Pleurisy	☐ Tuberculosis	☐ Other:	
SKIN			
☐ Eczema	☐ Psoriasis	☐ Hives	☐ Itching
☐ Acne	☐ Boils	☐ Melanoma	☐ Other:
HEAD			
☐ Headaches	☐ Migraines	☐ Head Injury	☐ Jaw / TMJ / Clicks
EYES			
☐ Impaired Vision	☐ Glasses or Contacts	☐ Blurriness	☐ Eye Pain / Strain
☐ Spots in Vision	☐ Color Blindness	☐ Double Vision	☐ Tearing or Dryness
☐ Glaucoma			
EARS			
☐ Impaired Hearing	☐ Earaches	☐ Ringing	☐ Dizziness
NOSE AND SINUSES			
☐ Nose Bleeds	☐ Stuffiness	☐ Hay Fever	☐ Sinus Problems
☐ Loss of Smell			
MOUTH AND THROAT			
☐ Frequent Sore Throat	☐ Copious Saliva	☐ Dry Mouth	☐ Gum Disease / problems
☐ Teeth Grinding	☐ Dental Cavities	☐ Hoarseness	☐ Sore Tongue / Lips

NECK			
☐ Goiter	☐ Lumps	☐ Swollen Glands	☐ Pain or Stiffness
CARDIOVASCULAR			
☐ Anemia	☐ Hearth Disease	☐ High Blood Pressure	☐ Poor Circulation
☐ Palpitations	☐ Stroke	☐ Chest Pain	☐ Heart Murmurs
☐ Rheumatic Fever	☐ Varicose Veins	☐ Irregular Heart Beat	☐ Mitral Valve Prolapse
☐ Angina	☐ Fainting	☐ Swelling in Ankles	☐ Blood Clots
☐ Deep Leg Pain	☐ Cold Hands / Feet	☐ Easy Bleeding or Bruising	
GASTROINTESTINAL			
☐ Nausea / Vomiting	☐ Abdominal Pain	☐ Ulcers	☐ Heartburn
☐ Belching	☐ Passing Gas	☐ Bloating	☐ Changes in Appetite
☐ Epigastric Pain	☐ Gall Bladder Disease	☐ Liver Disease	☐ Hepatitis B or C
☐ Hemorrhoids	☐ Crohn's Disease	☐ Gluten Sensitivity	☐ Irritable Bowel Syndrome
☐ Changes in Thirst	☐ Changes in Appetite		
GENITO -URINARY			
☐ Painful Urination	☐ Frequent Urination	☐ Frequent UTI	☐ Interstitial Cystitis
☐ Heavy Flow	☐ Impaired Urination	☐ Blood in Urine	☐ Urination at Night
☐ Kidney Stones	☐ Kidney Disease		
MUSCULOSKELETAL			
☐ Neck Pain	☐ Shoulder Pain	☐ Arm Pain	☐ Upper Back Pain
☐ Mid-Back Pain	☐ Low Back Pain	☐ Leg Pain	☐ Muscle Spasms / Cramps
☐ Joint Pain	If Joint Pain, where?		
NEUROLOGICAL			
☐ Vertigo / Dizziness	☐ Paralysis	☐ Loss of Balance	☐ Numbness / Tingling
☐ Seizures / Epilepsy	☐ Loss of Memory		
ENDOCRINE			
☐ Hypothyroid	☐ Hashimoto's	☐ Hyperthyroid	☐ Diabetes Type I or Type II
☐ Hypoglycemia	☐ Polycystic Ovarian Syndrome (PCOS)	☐ Metabolic Syndrome	☐ Night Sweats
☐ Feeling Hot or Cold	☐ Other:		

EMOTIONAL			
☐ Mood Swings	☐ Nervousness	☐ Depression	☐ Anxiety
☐ Mental Tension	☐ Eating Disorder	☐ Insomnia	☐ Suicidal
☐ Frustration	☐ Irritability	☐ Anger	☐ Over Thinking
☐ Sadness	☐ Grief	☐ Fear / Fright	☐ Other:

ENERGY & IMMUNITY			
☐ General Fatigue	☐ Awakens Unrested	☐ Fatigue After Meals	☐ Irritable Before Meals
☐ Slow Wound Healing	☐ Chronic Infections	☐ Chronic Fatigue Syndrome	☐ Frequent Colds
☐ Autoimmune Disease	☐ Allergies	☐ Hay Fever	☐ Chronically Swollen Glands
☐ Other:			

MALE REPRODUCTIVE			
☐ Prostate Problems	☐ Testicular Pain / Swelling	☐ Inguinal Hernias	☐ Other:
☐ Low Libido	☐ Sexual Difficulties	☐ Impotence	

FEMALE REPRODUCTIVE			
☐ Irregular Menstrual Cycles	☐ Painful Menses	☐ Heavy Menstrual Flow	☐ Bleeding Between Cycles
☐ Clotting	☐ Spotting	☐ Vaginal Discharge	☐ Premenstrual Problems
☐ Endometriosis	☐ Ovarian Cysts	☐ Cervical Dysplasia	☐ Difficulty Conceiving
☐ Menopausal Symptoms	☐ Sexual Difficulties	☐ Low Libido	☐ Nipple Discharge
☐ Regular Self Breast Exam	☐ Breast Lumps	☐ Breast Tenderness	☐ Other:

MENSTRUAL / BIRTHING HISTORY					
Age of First Menses:		Are your cycles regular?	☐Y / ☐N / ☐P	Date of Last Menstrual Period	
Length of cycle from one cycle to the next (days)?		How many days of bleeding during cycle?			
Type of Birth Control:		Dose:		Length of Use:	
Types of Birth Control used in Past:		Contraceptive Difficulties?			
Date of last PAP Exam:		Abnormal PAP exam?	☐Y / ☐N / ☐P	If yes, when?	
Are you pregnant now?	☐Y / ☐N	If yes, how many number of weeks?			
Number of Pregnancies:		Any complications with Pregnancy?			
Number of Live Births:		Number of Abortions:		Number of Miscarriages:	