

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Gender: Female Male (please circle)

Height: \_\_\_\_\_ Weight \_\_\_\_\_ weight fluctuations (seasonal, stress etc.) \_\_\_\_\_

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Any recent illness? \_\_\_\_\_

**Primary Care Physician:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Location (City): \_\_\_\_\_

**Reason for your visit today:** \_\_\_\_\_

Do you have a history of any of the following conditions?

- |     |    |   |
|-----|----|---|
| YES | NO | Heart attack or other heart disorders                 |
| YES | NO | Stroke or other brain disorders                       |
| YES | NO | High/Low blood pressure                               |
| YES | NO | Blood Clots or Thrombosis                             |
| YES | NO | Pulmonary Embolus                                     |
| YES | NO | Pneumonia/Tuberculosis                                |
| YES | NO | Shortness of Breath                                   |
| YES | NO | Asthma/Emphysema                                      |
| YES | NO | Hay fever/Allergies                                   |
| YES | NO | Rheumatic fever                                       |
| YES | NO | Fainting/Dizziness/Headaches                          |
| YES | NO | Convulsions/Epilepsy                                  |
| YES | NO | Anxiety/depression or psychiatric disorder            |
| YES | NO | Cancer chemotherapy                                   |
| YES | NO | Diabetes/Thyroid or other gland disorders             |
| YES | NO | Anemia or other blood disorders                       |
| YES | NO | Kidney/Liver disorders                                |
| YES | NO | Stomach/Intestine disorders                           |
| YES | NO | Bone/Joint disorders                                  |
| YES | NO | Skin/Hair disorders                                   |
| YES | NO | Sciatica/Carpal tunnel or other nerve disorders       |
| YES | NO | Eyes/Ears/Sinus disorders                             |
| YES | NO | Fibromyalgia or other muscle disorders                |
| YES | NO | Chronic fatigue                                       |
| YES | NO | HIV or other infectious diseases                      |
| YES | NO | Pain Pills or Shots                                   |
| YES | NO | Do you or your family members have a history of MRSA? |

Do you have any other illnesses not mentioned? \_\_\_\_\_

Date of last Chest X-Ray: \_\_\_\_\_ Date of last EKG: \_\_\_\_\_

Are you **allergic to any medications, food, and/or products?** \_\_\_\_\_ If yes, please list \_\_\_\_\_

Please list all current medications (Prescription and Over-the-Counter) \_\_\_\_\_

Please list any current Herbs or Vitamins you are taking \_\_\_\_\_

Do you have a history of cold sores, herpes or similar lesions? \_\_\_\_\_

List any previous surgeries (include cosmetic procedures/injuries/childbirth/hospital admissions)

Have you ever had excessive bleeding after surgery or dental work? \_\_\_\_\_

Have you ever experienced problems with anesthesia? \_\_\_\_\_

**Females:**

Are you pregnant? \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_ Number of Children \_\_\_\_\_

**Breast Surgery consultation Only:**

Bra Size \_\_\_\_\_ Size you would like to be: \_\_\_\_\_

Do you do breast self-examinations on a regular basis? \_\_\_\_\_

Do you have a family history of Breast Cancer? \_\_\_\_\_

Do you have a history of breast problems (i.e., cysts, lumps, etc)? \_\_\_\_\_

If so, what problems? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

Do you have any of the following (Y or N): Headaches \_\_\_\_\_ neck pain \_\_\_\_\_ shoulder pain \_\_\_\_\_

back pain \_\_\_\_\_ breast pain \_\_\_\_\_ skin problems under your breast \_\_\_\_\_

**Health Habits:**

How do you keep fit?

(Type/frequency) \_\_\_\_\_

Describe your present diet \_\_\_\_\_

Are you aware of any stress eating or eating disorders (Describe) \_\_\_\_\_

How much water do you drink? \_\_\_\_\_

Do you take any other food supplements? \_\_\_\_\_ If so, describe \_\_\_\_\_

Describe your caffeine intake: (soft drinks, coffee, chocolate etc.) \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how much? \_\_\_\_\_ Are you exposed to 2<sup>nd</sup> hand smoke? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If so, how much? \_\_\_\_\_ Do you take any recreational drugs? \_\_\_\_\_

What is your current skin care regimen? \_\_\_\_\_

Are you satisfied with this? \_\_\_\_\_

Is there anything else we should know about you? \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_