

Evergreen Integrative Medicine L.L.P.

Patient Health History

Name: _____ Age: _____ Date: _____
Reason for office visit: _____ Occupation: _____

Current Health Problems:	Current Medications/Vitamins:	Drug Allergies
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

How did you hear about us?

List all surgeries/accidents/injuries/hospitalizations: Family disease history-indicate family member/self

1.	asthma-
2.	arthritis-
3.	cancer-
4.	diabetes-
5.	epilepsy/seizures-
6.	heart disease-
Do you have any scars? Where?	high blood pressure-
	thyroid disease-
	mental illness or depression-
Describe past dental work you've had:	stroke-
	tuberculosis-
	other-

Lifestyle/ Diet: Have you had any immunizations? Which ones?

Do you smoke? How much?

Alcohol? (type, amount, frequency)

List past significant illnesses:

Exercise (type, frequency)

Caffeine/ Soda pop

Have you ever been on any medications for more than a week? Describe:

Overall stress level (low-moderate-high)

List examples of foods you eat for:

List any known allergies or sensitivities:
(food or environmental)

Breakfast:

Lunch:

Dinner:

List other Doctors/ Health Professionals:

Snack: