

EMMI: _____

Personal Information

Last Name _____ First Name _____ Middle: _____

Date _____ Sex [Check applicable]: Male Female Date of Birth: _____

Occupation: _____ Preferred Email Address: _____

Home phone: (____) _____ Cell Phone (____) _____ Preferred Cell or Home

Primary Physician's Name: _____ Phone Number: _____

Please list ALL ALLERGIES:

Medication Allergies	Non-Medical (food, pets, etc.)

Prescriptions, over the counter drugs, and supplements

*Please list any medications and supplements you take on a regular basis.

*****Please rate on a scale from 1 to 5 (1 being unnecessary and 5 being completely necessary), in your opinion, how necessary the medication/supplement is.*****

Drug Name	Dosage	# times per day	Purpose	Start date mm/yy	Any Noticeable Side Effects	*Rating (1-5)



PATIENT STAMP

Please check any of the following health issues that apply to you.

Check all That Apply	Date Diagnosed (mm,yy)	Check all That Apply	Date Diagnosed (mm,yy)	Check all That Apply	Date Diagnosed (mm,yy)
<input type="checkbox"/> Type 1 Diabetes	_____	<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Fibromyalgia	_____
<input type="checkbox"/> Type 2 Diabetes	_____	<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Crohn's Disease	_____
<input type="checkbox"/> Heart Attack/Coronary Artery Disease	_____	<input type="checkbox"/> Sleep Apnea	_____	<input type="checkbox"/> Peripheral Disease	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Migraine/Headache	_____	<input type="checkbox"/> Depression	_____	<input type="checkbox"/> osteoarthritis	_____
		<input type="checkbox"/> Asthma	_____		_____

Do you have any other medical issues that you feel we should be aware of? Yes No

If "Yes", please explain: _____

Personal Questions continued:

1) Are you on a special diet? Check all that apply

- None
- Vegetarian
- Vegan
- Lactose intolerant
- Gluten free
- Other _____

2) What meals do you eat? Check all that apply

- Breakfast
- Lunch
- Dinner
- Snacks

3) How many snack do you usually give yourself per day? _____

4) What foods do you need to reduce your consumption of to achieve your goals?

5) Have you recently:

- Gained weight
- Lost weight
- Neither

6) If your weight has changed, How much? _____

7) Over what period of time? _____

8) Who is in your household? [Check all that apply]

- Spouse
- Children? If yes how many? _____
- Other relatives
- Pets
- Other _____

9) What responsibilities do you juggle? Check all that apply

- Work
- Housework
- Child Care
- Volunteer work
- Taking care of pets
- Other

10) Have you experienced any major life events within the past year?[Check all that apply]

- Marriage
- Divorce
- Pregnancy
- Career change
- Moved
- Death of a loved one
- Major illness or injury
- Other_____

11) What other barriers make it difficult to focus on taking care of yourself?

12) What do you hope to accomplish at Pro Health?

Family History:

Does anyone in your family (siblings, parents, or grandparents) have a history of any medical conditions? (ie: Cancer, Diabetes, Hypertension, etc.)

Siblings:_____

Mother:_____ Father:_____

Maternal Grandmother:_____ Paternal Grandmother:_____

Maternal Grandfather:_____ Paternal Grandfather: _____