New Patient Health History

Name: _____ Date: _____

Please list any traumas or surgeries you have had:

_____
_____
_____
_____

Please list any past/present health conditions (cancer, diabetes, hypertension, etc):

_____
_____
_____
_____

Please list any medications/supplements you take:

_____
_____
_____
_____

Please circle any symptoms you are experiencing:

Weight gain	Constipation	Anxiety
Weight loss	Bloating/gas	Trouble urinating
Fatigue	Change in vision	Incontinence
Fevers	Change in hearing	Sexual dysfunction
Dizziness	Numbness/tingling	Feeling cold
Heartburn	Weakness	Feeling hot
Diarrhea	Depression	Rashes

Have you had any tick bites? Yes/No

Smoking status? Current smoker Former smoker Never smoked