Initial Patient History: Date _____

Name_____ Date arrival in L.A. _____

Age _____ Date of birth____/_____/_____ Birth Place_____ Ethnicity_____

Referred by_____ Reason for referral _____

PCP_____ Other Physicians & specialty _____

Chiropractor_____ Acupuncture_____ Other_____

Occupation/retired (date) _____

Marital status: single married separated divorced widowed partnered
Highest education: grade school high school. College: major. Graduate (field, degree) _____
Do you use the Internet for medical information: Y N
Reports should be sent to whom? _____

Cardiovascular History (circle, date)

Abnormal EKG
Heart attack
Coronary stents
Coronary Bypass surgery
Pacemaker
Rhythm ablation/Holter
Carotid artery disease /surgery/stent
Aneurysm
Body/Heart scan
High cholesterol
Murmur/heart valve disease
Echocardiogram/carotid US
Stress test
Chest x-ray
Current smoker

Chest pain/pressure
Shortness of breath
Severe ankle swelling
Palpitations
Stroke/TIA
Diabetes/gestational
Congestive heart failure
Ovarian cysts/POS
Erectile dysfunction
Chronic arthritis/rheumatoid
Psoriasis/lupus
High blood pressure
Deep vein thrombosis
Gout
Calf pain when walking

Stress: grade 1-10: home_____ Work_____ Average sleep duration _____
Circle stress relievers: exercise meditation yoga others: _____

Current Medications: include prescriptions, over the counter supplements, herbs, vitamins with strength and frequency:

Discontinued medications:_____

Exercise: what kind, how often, how long_____ **Weight goal**: _____

Eating: who cooks? _____ Diet: unrestricted? Other: _____

Where do you eat breakfast_____ Lunch_____ How often do you eat out_____

 Name: _____

Smoking history includes cigarettes, cigars, chewing tobacco.
Current smoker? Y/N. Age started: _____ Packs/day_____ # years_____
Past smoker? Y/N. Year quit_____. Exposed to second hand smoke? Y N
Drinking history includes all alcoholic beverages (beer, wine, hard liquor, mixed).
Current drinker: Y/N. #Drinks per day/week/month/year _____. Age started_____
Past drinker: Y/N. Previous consumption: # per week/month/year _____. Year quit _____

Caffeine consumption (coffee, tea, chocolate, Coke, Pepsi, others): #per day_____
Recreational drug use: what/when_____

Current and past medical problems (circle & date): cancer, anemia, asthma, cough, cataracts, glaucoma, chronic fatigue, indigestion, colitis, bronchitis, TBC, urinary, insomnia, AIDS, sinusitis, headaches, heartburn, emphysema (COPD), hepatitis, diarrhea, phlebitis, prostate, thyroid, seizures, ulcers, constipation, depression/anxiety, kidney stone/infection, liver disease, nausea/vomiting, psychiatric illness. Others_____
Injuries, fractures, concussions_____
Surgeries: _____
Hospitalizations: _____

Family history - Indicate heart attack, angina, bypass graft, stent, stroke/TIA, diabetes, organ transplant.

Family Members	Living Age	Illness(es)	Age Deceased	Cause of death
Father				
Mother				
Paternal Grandparents				
Maternal Grandparents				
Brothers				
Sisters				
Daughters				
Sons				
Paternal aunts, Uncles, cousins				
Maternal aunts, Uncles, cousins				
Husband/wife				