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Patient Forms: Health Profile

PATIENT INFORMATION		
Name *(First Last)*:	M F	**DOB:**
Address: City:	**State:**	**Zip Code:**
Email:		
How did you hear about us?		
Primary phone: cell landline	**Occupation:**	
Today's date:	**Reason for visit:**	

REVIEW OF CURRENT SYMPTOMS
Describe your symptoms:
What caused your present symptoms (if known) and when did they begin?
Symptoms are located: right side left side front midline back *Comment:*
Symptoms are: occasional intermittent frequent constant *Comment:*
Level of discomfort: low severe *Comment:*
What treatments have you tried to resolve your symptoms?
What helps/makes you feel better?
What hurts/makes you feel worse?

HEALTH HISTORY
Previous Medical Conditions & Dates
Previous Traumas (fractures, car accidents, etc.) & Dates
Previous Surgeries & Dates
Family/Hereditary Health Issues

CURRENT HEALTH STATUS		
Exercise	Frequency**:**	
	Activities**:**	
Medication	Name	Reason
Systemic/underlying health conditions:		
Medical problems diagnosed by other doctors:		

Constitutional Health lack of energy, unexplained weight loss/weight loss, change in appetite, fever, night sweats	Yes	No	**Describe:**
Ears, Nose, Mouth, Throat difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain, numbness	Yes	No	**Describe:**
Cardiovascular/Circulatory bruising, slow clotting, irregular heartbeat, racing heart, chest pains, swelling in extremities	Yes	No	**Describe:**
Respiratory shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray	Yes	No	**Describe:**
Gastrointestinal heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence	Yes	No	**Describe:**
Genitourinary bladder condition/symptoms, prostate condition, decrease in desire, infertility	Yes	No	**Describe:**
Musculoskeletal joint pain, muscle weakness, decreased range of motion, disc injury, scoliosis, stenosis, neuropathy	Yes	No	**Describe:**
Integumentary rash, itching, skin lesion, hair loss, change in skin tone	Yes	No	**Describe:**
Neurologic headaches, visual changes, weakness, sensory changes, numbness/tingling, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions	Yes	No	**Describe:**
Psychiatric irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, addiction	Yes	No	**Describe:**
Endocrine intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive	Yes	No	**Describe:**
Immunologic autoimmune disease, seasonal allergies, systemic itching, frequent infections	Yes	No	**Describe:**

After completing this document, please either print it and bring the hard copy with you to your appointment, or save and email it to: frontdesk@drbrianstutz.com.

Thank You!