Health Assessment Form

Patient Information

Name: ______________________ Date of birth: __________ Gender: __________

Address: ____

City: ______________ State: ______________ Zip Code: __________

Phone Number: ______________ Email: ______________________

Medical History

Please indicate if you have ever been diagnosed with or experienced any of the following medical conditions:

High blood pressure: ☐ Yes ☐ No

Heart disease: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Chronic obstructive pulmonary disease (COPD): ☐ Yes ☐ No

Thyroid disorder: ☐ Yes ☐ No

Depression or anxiety: ☐ Yes ☐ No

Cancer: ☐ Yes ☐ No

Autoimmune disease: ☐ Yes ☐ No

Other (please specify): ______________________

Current Medications

Please list all medications you are currently taking, including dosage and frequency:

1.) ____

2.) ____

3.) ____

4.) ____

5.) ____

Allergies

Please indicate if you have any allergies or adverse reactions to the following:

Medications: ____

Foods: ____

Environmental factors (such as pollen, dust, or mold): ______________________

Family History

Please indicate if any of your family members have been diagnosed with or experienced any of the following medical conditions:

High blood pressure: ____________________

Heart disease: ____________________

Stroke: ____________________

Diabetes: ____________________

Asthma: ____________________

COPD: ____________________

Thyroid disorder: ____________________

Depression or anxiety: ____________________

Cancer: ____________________

Autoimmune disease: ____________________

Other (please specify): ____________________

Lifestyle Factors

Please answer the following questions regarding your lifestyle:

Do you smoke or use any tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes/packs per day or how often do you use tobacco products? ____________________

Do you consume alcohol? ☐ Yes ☐ No

If yes, how many drinks per week? ____________________

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercise and how often? ____________________

Comments

Please use the space below to provide any additional comments or information you would like to share: