PATIENT PROFILE

NAME:____

ADDRESS: ____

CITY: ______________________STATE: ______ ZIP: ______________COUNTY: ________________

HOME PHONE: _______________________ WORK PHONE: ____________________________________

FAX: _______________________________ EMAIL: ____

AGE: _________ HEIGHT: _________ WEIGHT: ____________ DOB:_________________________

REFERRED BY: ____

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Please list, in order of importance, your reasons for seeing Dr. Anderson:

1. __________________________________ 4.____

2.___________________________________ 5.____

3. ___________________________________ 6. ____

Please list any surgeries you have had, along with the dates:

____

____

Please list any pharmaceutical medications that you are currently taking:

____

____

Name of Family Physician: _____________________Date of last physical/check up:

____

Marital Status: (circle) Married Single Divorced Other

Occupation: ____________________________ Retired?: _______________________________________

Where were you raised? ____

Vaccinated? YES: ___________________ NO:______________ SOME: ____________________________

Describe any diseases that are prominent in your family: __________________________________

____

WOMEN ONLY: Date of last menstruation: ____

Are you now on or have you ever taken birth control? __________ How long? _________________

If menopausal; date of last GYN visit:

____

Are you pregnant or nursing? ________________ Do you have children? ___________________________

LIFESTYLE PROFILE

Are/Were you a smoker? ________ How long? _______ How Much? ________ Quit? ___________________

Did/Do you drink coffee? ________ How long? _______ How much? _________Quit? _________________

Did/Do you drink carbonated beverages? _____________ How much? _________ Quit?

____

Do you eat large amounts of chocolate? ____

Do you exercise? _______________ How Often? ___________ What type? ___________________________

Do you use a micro-wave oven? ___________ Electric Blanket? ______________ Water bed?______________

Do you have amalgam dental fillings? ____________________ How many? ____________________________

Have you had any fillings removed? ____________ When? ____

Do you have any root canals? ________ How many? _______ Crowns? __________ Other? _______________

Do you use aluminum cookware? ____

Do you use antacids? ____

What type of deodorant do you use? ____

What drugs have you taken? (Including prescription, over the counter, or recreational) ____________________

____

Are there any high tension lines or step down transformers near your home or where you work?

____

Please give a diet summary for a three day period.

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Please list any supplements that you are taking NOW.

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