PATIENT INFORMATION AND HEALTH SUMMARY

Please complete the following confidential information and bring it to your appointment.

NAME_____/_____/_____
Last First M.I.

ADDRESS_____/_____/____/_____
Street City State Zip Code

PHONE (_____)_____ **EMAIL** _____ **SEX** ☐ **Male** ☐ **Female**

Date of Birth _____/_____/_____ **Height** _____ **Weight** _____
Month Day Year

Please list your health care providers and the date of your last visit:

Name:_____ **Name:**_____

Specialty:_____ **Specialty:**_____

Date of Last Visit:_____ **Date of Last Visit:**_____

When was your laboratory tests last done? _____

Please request a copy of labs done in the past 1-2 years and bring this with you to your appointment.
Have you had a 25-OH Vitamin D level done in the past year? ☐ **Yes** _____ **ng/ml** ☐ **No**

Have you had any surgeries? ☐ **Yes** ☐ **No** **If yes, what and when?**_____
Do you drink caffeinated beverages? ☐ **Yes** ☐ **No** **If yes, how much and how often?**_____
Do you drink alcohol? ☐ **Yes** ☐ **No** **If yes, how much and how often?**_____
Do you smoke? ☐ **Yes** ☐ **No** **If yes, how many packs per day?**_____
Do you use any other substances? ☐ **Yes** ☐ **No** **If yes, what, how much, and how often?**_____
_____
Do you eat regularly (e.g., every 4-6 hrs) and have well balanced meals? ☐ **Yes** ☐ **No** **If no, describe what meals you skip and describe your diet** _____
_____
_____
Do you exercise? ☐ **Yes** ☐ **No** **If yes, what type and how often?**_____

Are you currently on any prescription or non-prescription medications/supplements? ☐ **Yes** ☐ **No**

If yes, please list the medications and/or supplements with doses per day on the lines below:

Medications	Supplements
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____

MEDICATION ALLERGIES (please check all that apply):

☐ None known ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Codeine

If allergic to any of the above medications, please describe what happens:_____

Please list any other medication and/or food allergies you have:_____

_____

Consultation/Assessment Information

MEDICAL HISTORY

Your Past/Current Medical Conditions (please check all that apply)	
☐ Anxiety Disorder (type:_____)	☐ Arthritis
☐ Asthma	☐ Blood Clots (DVT, pulmonary embolism)
☐ Cancer (type:_____)	☐ Clotting Disorder
☐ Chronic Fatigue Syndrome	☐ Eating Disorder
☐ Depression or Mood Disorder	☐ Fibromyalgia
☐ Diabetes (type:_____)	☐ Gallbladder Disease
☐ Epilepsy	☐ High Cholesterol
☐ Fractures	☐ Kidney Disorder
☐ Headaches/Migraines	☐ Thyroid Disorder
☐ Heart Condition (type:_____)	☐ Ulcers
☐ High Blood Pressure	☐ Vericose Veins
☐ Insomnia	☐ Other:_____
☐ Liver Disorder	
☐ Premenstrual Syndrome	
☐ Perimenopause (irregular periods)	
☐ Menopause (no periods > 12 months)	
☐ Osteoporosis/Osteopenia	

Family History (please check all that apply)	
☐ Cancer: type-_____ who?_____	☐ Heart Disease: who?_____
☐ Diabetes: type-_____ who?_____	☐ Alzheimer's Disease: who?_____
	☐ Osteoporosis: who?_____
	☐ Psychiatric Disorder: who?_____

Reason for consultation in own words:

PATIENT SIGNATURE_____ **DATE**____/____/____

ASSESSMENT AND PLAN

SIGNATURE: _____ **DATE:** _____

Martha (Martie) Fankhauser, MS Pharm.

Comments: _____