

Are you allergic to any medications? Yes No

If yes, please list, with reaction:

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Primary Care Doctor: \_\_\_\_\_

Cardiologist /Other Specialists: \_\_\_\_\_

Have you been diagnosed with any of the following:

High Blood Pressure/Date: \_\_\_\_\_

Asthma/ Emphysema / Other Respiratory Conditions / Date: \_\_\_\_\_

Heart Disease / Surgeries / Date: \_\_\_\_\_

Diabetes / Date: \_\_\_\_\_ Average blood sugar: \_\_\_\_\_

Last hemoglobin A1C / Date: \_\_\_\_\_

Does your vision fluctuate after eating? Yes No

Stroke / Date: \_\_\_\_\_ Did it affect your vision? Yes No

HIV / Date: \_\_\_\_\_ T-cell count / Date: \_\_\_\_\_

Ear, Nose, Throat Conditions / Date: \_\_\_\_\_

Gastrointestinal Conditions / Date: \_\_\_\_\_

Genitourinary Conditions / Date: \_\_\_\_\_

Allergies or Autoimmune Conditions / Date: \_\_\_\_\_

Arthritis (Circle Osteo / Rheumatoid) / Date: \_\_\_\_\_

Other Musculoskeletal Conditions / Date: \_\_\_\_\_

Migraines / Date: \_\_\_\_\_

Other Neurological Conditions / Date: \_\_\_\_\_

Endocrine Conditions / Date: \_\_\_\_\_

Rosacea / Date: \_\_\_\_\_

Other Skin Conditions / Date: \_\_\_\_\_

Blood Conditions / Date: \_\_\_\_\_

Cancer/ Type/ Date: \_\_\_\_\_

Hepatitis / Type / Date: \_\_\_\_\_

Are you pregnant now? Yes No

List any surgeries or hospital stays you've had in the last 10 years (Include dates):

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Do you / did you ever smoke? Yes No

If yes, how many packs / day? \_\_\_\_\_

For how many years? \_\_\_\_\_

When did you quit? \_\_\_\_\_

Do you drink alcohol? Yes No

If yes, how many glasses / day? \_\_\_\_\_