NABHCO CLINIC

General Patient Information

Patient Gender *

Patient Name *

First Name Last Name

Patient Height (inches) *

Patient Weight (pounds) *

Patient E-Mail *

example@example.com

Reason for seeing the doctor: *

Patient Medical History

Please list any drug allergies

Have you ever had (Please check all that apply)

- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Gout
- ☐ Diabetes
- ☐ Emotional Disorder
- ☐ Epilepsy Seizures
- ☐ Fainting Spells
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Digestive Problems
- ☐ Ulcerative Colitis
- ☐ Ulcer Disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Sleep Apnea
- ☐ Use a C-PAP machine
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Neurological Disorders
- ☐ Bleeding Disorders
- ☐ Lung Disease
- ☐ Emphysema

Other illnesses:

Please list any Operations and Dates of Each

Please list your Current Medications

Healthy & Unhealthy Habits

Exercise

- ○ Never
- ○ 1-2 days
- ○ 3-4 days
- ○ 5+ days

Eating following a diet

- ○ I have a loose diet
- ○ I have a strict diet
- ○ I don't have a diet plan

Alcohol Consumption

- ○ I don't drink
- ○ 1-2 glasses/day
- ○ 3-4 glasses/day
- ○ 5+ glasses/day

Caffeine Consumption

- ○ I don't use caffeine
- ○ 1-2 cups/day
- ○ 3-4 cups/day
- ○ 5+ cups/day

Do you smoke?

- ○ No
- ○ 0-1 pack/day
- ○ 1-2 packs/day
- ○ 2+ packs/day

Include other comments regarding your Medical History