

Health and Lifestyle Profile

All questions contained in this profile are strictly confidential and will become part of your medical record. This profiling is designed to gain insight into your health and lifestyle to personalize health programs tailored to your uniqueness.

Name:	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Family physician:	Date of last physical exam:	

What are your health concerns? Please list in the **order of importance** to you.

Health concern	Date started	Diagnosis given	Treatments received
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Has anything recently changed or become worse?

Do you have any insights about your health concerns?

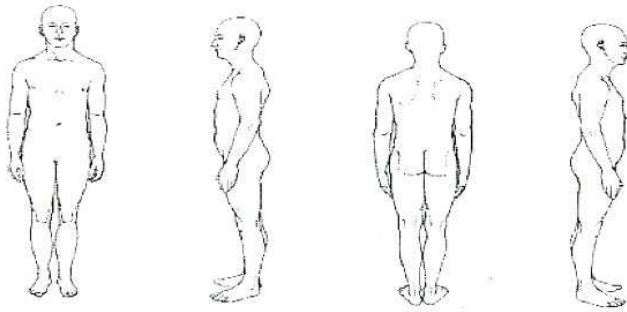
Please state your health goals:

Please list any surgeries or hospitalization:

Year	Reason	Hospital/Length of stay

Have you ever had a blood transfusion? Yes No

Please indicate areas of your discomfort in the following diagrams.



Please list any allergies to medication, foods or environmental factors:

Please check any of the following that you are currently taking or using.

- | | |
|-------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Chemotherapy / Radiation |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Diuretics (water pills) |
| <input type="checkbox"/> Appetite suppressants / Diet pills | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Aspirin/Tylenol | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Pain relievers |

Number of times on antibiotics in the last 10 years: _____

List your current prescribed medication, over-the-counter medications, vitamins, and herbs. Use a separate sheet if needed.

Name	Dosage/Frequency	Reason for use	Start date

PERSONAL LIFESTYLE:

Habits:

Tobacco: N Y, how many years? _____; How many cigarettes per day now? _____; Year stopped _____

Are you exposed to second hand smoke? N Y

Caffeine (coffee, tea, or pop)? N Y, how much daily _____

Alcohol? N Y, how much _____

Recreational drugs? N Y, what kind _____, how much _____

Regular exercises? N Y, what kind _____, how often _____

Diet:

Describe your average day meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

List foods that you crave: _____

Are there any diet restriction or regimens that you follow? Please describe: _____

Sleep:

Average hours of sleep per night: _____ Do you take pills or herbs to help you sleep? Yes No

Do you have difficulty sleeping? daily often sometimes never

Do you dream? daily often sometimes never

Do you wake up feeling refreshed? Yes No

Energy Level

On a scale from 1 to 10, rate your energy level, where 1 is low and 10 is high. _____

What time of day is your energy at its peak? _____

What time of day is your energy at its lowest? _____

What affects your energy? _____

FAMILY HISTORY:

	Who	Comments		Who	Comments
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Autoimmune Disease			Kidney disease		
Asthma			Mental Illness		
Cancer			Stroke		
Diabetes			Tuberculosis		
Epilepsy			Other		

Clarification of Health Goals:

What are your short -term health goals?

What are your long -term health goals?

Please add any other relevant health/personal information that you feel is missing.

Please list any questions/concerns you would like to ask Dr. Carol Lin during your visit.
