BRYANT
MEDICAL GROUP
RESTORE • REGENERATE • REVIVE

Name _____ *Age* _____

Address

Home Phone	
Cell Phone	
Birthday	

Appt Time/Date _____

Prioritize Health Concerns

Priority	Health Concern	Date of Onset	Severity	Frequency
1				
2				
3				
4				
5				

Goals for yourself _____
Describe yourself _____
_____

Past Medical Problems

Disabilities _____

Health as a child: Any illnesses?/birth injuries?/vaginal delivery or C-Section? _____
_____

Past Surgery

Procedure	Date	Any continuing problems?

Meds/Allergies

Allergies to meds/foods/environment?

Allergy	Date of Onset	How do you Treat?

Medications including over the counter

Medicine	Reason	Dose	Frequency	Date started	Side effects

Herbs/supplements/vitamins

Product	Brand	Dose	Reason	Freq	Date start	Side Effec

Experience with alternative/complementary medicine _____

_____

_____

_____

Family History

Are you adopted? Yes/No

Health of immediate family

	Age	State of Health	Diagnosis
Mother			
Father			
Mat GM			
Mat GF			
Pat GM			
Pat GF			
Sibling			
Sibling			
Children			

Lifestyle Concerns

Do you have any Pain?

Where	Scale 1-10 *	Date it started	What makes it better	What makes it worse

*0-no pain/10-worst pain ever

When is your energy level highest? Morning/afternoon/night

Lowest? Morning/afternoon/night

Sleep pattern:

Time to Bed	
Time You Awaken	
How long does it take to get to sleep	
How many hours you sleep	

What happens at night?	
Do you wake up?	
Do you nap? How long?	
Any recent changes?	

Do you dream? Yes/No

Do you remember your dreams? Yes/No

Any recurring dreams? _____

Nutrition history

Any Particular Diet?_____ eating habits_____
Body image Good_____Bad
History or ongoing problem of anorexia/bulimia/other?_____
Weight/height _____ Are you happy with your weight? Yes/No
Weight 5 yr ago_____ Weight at age 21 _____
Recent weight changes? Yes/No How Much_____

Who prepares your food?_____
Eat alone? Yes/No Standing/driving?
Organics?_____
Cravings?_____
Food dislikes?_____
Do you eat out a lot? Yes/No Do you eat fast food? Yes/No

Frequency of Foods:

	None	A Little	Moderate	A Lot
Fruit				
Veggies				
Red Meat				
Poultry				
Fish				
Whole grains				
Beans				
Soy				
Dairy				
Fats				

Substance Use	# years	How much/day	
Alcohol			
Tobacco			
Caffeine			
Other			

Social history:

Who do you live with?_____
How is your home life?_____
Marital history_____
Most positive significant relationships_____
Most negative_____
Community?_____
Religion/spirituality_____
Financial hardships?_____
What is a typical day/week for you?_____
_____

How many hours in a day do you spend :	Hours spent day or week?	Do you want to increase or decrease?
Work		
Child Rearing		
School		
Exercise		
TV		
Video Game		
Cell phone		

Past work history_____
_____
Birth place_____
Where have you lived and for how long?
_____
_____

Hobbies/interests_____
Do you read? If so, what? (newpaper, magazines, books)
Favorite book/movie/TV show/ music_____
Volunteer work?_____

Do you have any history of mental/physical abuse? Yes/No

Stress Level 1----------10(hi stress)
What do you do to relax?_____
What are your supports?_____
What have your tried?_____

Do you have Depression? _____
Important stressful anniversaries-birth/death/accident/losses _____
_____

Traumas that have affected you_____

_____

PTSD?_____

Preventative Health

Exercise program_____

History of exercise_____

Sun exposure Hrs/day_____ Do you wear Sunscreen? Yes/No Type?_____

Auto safety: seatbelts/carseats

Weapons in house? Yes/No

Smoke detectors? Yes/No

Carbon monoxide detector? Fire extinguisher? (Circle if you have)

Possible Lead Esposure?_____

Disaster readiness? Yes/No

Do you feel safe? Yes/N

Labs

Lab	Result	Date

Avg BP _____

Immunization history
