Natural Healing Medical Center
&
WeightLossMEDICAL

2058 S. Dobson Road, Suite 7, Mesa, AZ 85202
Tel: 480-949-1500 Fax: 480-949-1501

PATIENT PROFILE

Date: ________________

Please complete this questionnaire as *thoroughly* as possible in order to aid in your diagnosis and treatment. This is a confidential record and will not be released without your authorization to do so.

Name ____ Age _______ Birth date _________________

Height _______ Weight _______ Male ❑ Female ❑

Street Address ____

City ____________________________________ State_________ Zip Code ___________________

Phone (home) ________________(Cell) _________________Occupation ____________________________

Email address ____

Spouse Name ___________________________________ Phone:____________________________________

Emergency Contact ___________________________________ Phone # ________________________________

How did you hear about our clinic? ____

PRESENT HEALTH CONCERNS

Please list your present health concerns, in order of significance.

1. ____
2. ____
3. ____
4. ____

MEDICAL HISTORY

Have you ever had *or* currently have any of the following:

Allergies	❑	Headaches	❑
Alcoholism	❑	Heart Disease	❑
Anemia	❑	Hepatitis	❑
Asthma	❑	Kidney Disease	❑
Autoimmune Dz	❑	Mental Illness	❑
Cancer	❑	Stroke	❑
Diabetes	❑	Tuberculosis	❑
Epilepsy	❑	Other _______________	❑

Surgeries ____

____

Major Accidents ____

____

Hospitalizations ____

____

Current Medications ____

Vitamins/Minerals ____

Herbs or Homeopathics ____

Family History Father Mother Sister Brother

Illness:

ALLERGIES:

Drugs ____

Food ____

Environmental (grasses, pollens, etc.) ______________________________

Last Complete Physical Exam Month _______Year ____Dr. __________________

FOR WOMEN

Last Pap Smear Month _______________Year ___________ Dr. ____________

Results? ❑ Normal ❑ Abnormal (please specify) ____________________________

Women Health Concerns? ____

____

PERSONAL HABITS

Check if you use any of the following:

❑ Tobacco ❑ Caffeine ❑ Alcohol ❑ Recreational Drugs

Are there any diet restrictions or regimens that you follow? If yes, please describe __________

____

____

How many hours of sleep do you get? ____

Sleep difficulties? ____

Do you have a regular exercise program? If yes, please describe ________________________

____

SOCIAL HISTORY

Single ❑ Married ❑ Significant Other ❑ Years __________________

Children: No ❑ Yes ❑ How many ________ Age(s) ________________________

I understand that all fees are due at the time of service. I am financially responsible for payment of this account and Natural Healing Medical Center will not bill any insurance company.

Patient (or Guardian's) Signature: ___________________________________ **Relation to Patient:**__________________