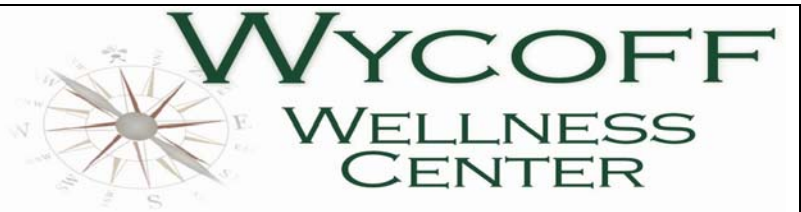

1226 Michigan Avenue
East Lansing, Michigan 48823
517-333-7270 (Phone)
800-471-0255 (Toll free phone)
517-333-1801 (Fax)
wycoffwellness.com

MEDICAL HISTORY INTAKE INFORMATION SHEET

DEMOGRAPHIC INFORMATION

Name:	Date of Birth:
Employer:	Occupation:
With whom do you live?	Today's date:

CURRENT MEDICAL PROBLEMS

What are your current medical problems or concerns? What treatments have been tried in the past?

CHRONIC MEDICAL PROBLEMS

Check any of the following medical problems ***currently*** being treated.

High blood pressure		Cancer		Asthma		Irritable bowel disease	
Heart disease		Depression		Lung disease		Headaches	
High cholesterol		Seizure		Low thyroid		Prostate problems	
Chest pain		Pain with daily activities		Stomach problems		None of the above	

SURGICAL HISTORY

Please list any surgeries you have had and when they occurred:

Surgery	Month/Year

FAMILY HISTORY (Blood relatives)

	Father	Mother	Sister	Brother	Grandparents	Aunt	Uncle
Hypertension							
Heart disease							
High cholesterol							
Osteoporosis							
Depression							
Breast cancer							
Ovarian cancer							
Colon cancer							
Prostate cancer							
Diabetes							
Other (please list)							
Age (current or at death)							

Contraception: Yes _____ No _____ N/A _____ What form?

Females only:

Last menstrual period: | How frequent: (# of days):

Was your flow light _____ Medium _____ Heavy _____

CURRENT MEDICATIONS & SUPPLEMENTS

Please include prescription, over the counter, and herbal medications.

Medication	Dose	How often taken/used?

DRUG ALLERGIES/REACTIONS

Medication	Reaction	Date of reaction

HEALTH HABITS

Smoking currently: Yes _____ No_____ Past smoking: Yes _____ No _____
If yes, how much do or did you smoke? _____ For how many years? _____
Are you interested in quitting? _____

Alcohol: Yes _____ No _____
If yes, how much do you drink? _____ How often? _____

Illicit Drugs: Do you use any street drugs? Yes _____ No _____ What type(s) _____

Caffeinated beverages: Yes _____ No _____
How many per day? _____

Exercise: Yes _____ No _____
What kind of exercise? _____ How often? _____

Sleep pattern: How many hours of sleep do you routinely get? _____
Do you feel rested upon waking? Yes _____ No _____ Do you snore? Yes _____ No _____

Safety issues: Do you wear seatbelts whenever in a vehicle? Yes _____ No _____
Do you wear a bike helmet if riding a bike? Yes _____ No _____
Are there any guns in your home? Yes _____ No _____

Has anyone ever hit kicked, slapped, or used force upon you in any way? Yes _____ No _____
If yes, please describe. _____

_____ _____

Patient signature

If a minor, responsible party/guardian signature