



# DIETARY HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_ Date: \_\_\_\_\_

Wt.: \_\_\_\_ lbs. Ht: \_\_\_\_' \_\_\_\_" BMI: \_\_\_\_\_ Waist Circumference: \_\_\_\_\_ Abdominal Circ.: \_\_\_\_\_

BP: \_\_\_\_/\_\_\_\_ Hypertension? \_\_\_\_ Pulse: \_\_\_\_ Arrhythmia's? \_\_\_\_ CVD? \_\_\_\_\_ Kidney Dis.? \_\_\_\_

Diabetes? \_\_\_\_ Type I or Type II (Circle) Swollen Ankles? \_\_\_\_\_ Arthritis? \_\_\_\_\_

Medical Hx (Surgeries/Trauma's (MVA's, Fx's)/Concussions/Hospitalizations): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family Hx (Diabetes/Heart Disease/Stroke/Cancer etc.): \_\_\_\_\_

\_\_\_\_\_

Nutrition Hx (Special diets/Supplements/Previous Care/Habits/Eating Disorders-Bulimia or Anorexia): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you think your issues with food are more genetic, psychological, chemical or social? And explain why? \_\_\_\_\_

\_\_\_\_\_

Usual Eating Patterns (include timing and location of meals & snacks): \_\_\_\_\_

\_\_\_\_\_

Food preferences: \_\_\_\_\_

\_\_\_\_\_

Allergies & Food Intolerances: \_\_\_\_\_

\_\_\_\_\_

Vitamins, Minerals & Supplement Use: \_\_\_\_\_

\_\_\_\_\_

Any changes in desire/craving for foods (Sugars, fats or salts) (satiety earlier or pain or discomfort)? \_\_\_\_\_

\_\_\_\_\_

Dental or oral problems (Chewing/Cavities/Dentures): \_\_\_\_\_

Bowel Habits (be descriptive-Gas/Bloating/Yeast/Stool frequency and soft or hard): \_\_\_\_\_

Do you over eat or eat to the point where you feel physically ill? \_\_\_\_\_

Do you feel tired or fatigued after eating? \_\_\_\_\_

Do you find yourself constantly eating certain foods during the day? \_\_\_\_\_

Do you become agitated, have anxiety or other physical symptoms when you cut down on certain foods? \_\_\_\_\_

Have you ever consumed certain foods to prevent those feelings of agitation or anxiety from developing? \_\_\_\_\_

Pain during meals, after meals with any foods? \_\_\_\_\_

Amount of Water Usage/Day? \_\_\_\_\_ 8 oz. glasses/day (City/Tap/Well/Filtered/ Hydration Status): \_\_\_\_\_

Other Liquids? (Coffee, soda, sports drinks, tea, milk and how much?): \_\_\_\_\_

#### **Nutritional Informed Consent**

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g)(1), the term "Drug" is defined to mean:  
*"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a mineral, trace element, amino acid, herb, or homeopathic remedy.

Although a vitamin, a mineral, trace element, amino acid, herb or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of goods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT SYMPTOM SURVEY

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_ O<sub>2</sub> \_\_\_\_\_

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...

## Primary Complaints

- |  |  |  |
|--|--|--|
| 090 <input type="checkbox"/> General Good Health   | 039 <input type="checkbox"/> High Blood Pressure 401.9                       | 063 <input type="checkbox"/> Prostate Disorder 602.9   |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis                      | 040 <input type="checkbox"/> Low Blood Pressure 458.9                        | 069 <input type="checkbox"/> Hyperthyroidism 242.90  |
| 001 <input type="checkbox"/> Skin Disorder 692.9   | 041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00            | 070 <input type="checkbox"/> Hypothyroidism 244.9  |
| 002 <input type="checkbox"/> Acne 706.1  | 042 <input type="checkbox"/> Numbness 782.0                                  | 071 <input type="checkbox"/> Systemic Lupus 710.0  |
| 003 <input type="checkbox"/> Psoriasis 696.1   | 043 <input type="checkbox"/> Constipation 564.0                              | 072 <input type="checkbox"/> Infertility, female 628.9   |
| 004 <input type="checkbox"/> Urticaria (Hives) 708.9                                       | 044 <input type="checkbox"/> Indigestion 536.8                               | 073 <input type="checkbox"/> Interstitial Cystitis 595.1                                       |
| 005 <input type="checkbox"/> ADD/ADHD 314.00/314.01  | 045 <input type="checkbox"/> Ulcerative Colitis 556.9                        | 074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4                                   |
| 006 <input type="checkbox"/> Allergies, Unspecified 477.9                                  | 046 <input type="checkbox"/> Depression 311                                  | 075 <input type="checkbox"/> Menopausal Symptoms 627.2   |
| 007 <input type="checkbox"/> Allergic Rhinitis from food 477.1                             | 047 <input type="checkbox"/> Diabetes Mellitus 250.0                         | 076 <input type="checkbox"/> Hot Flashes 627.2   |
| 008 <input type="checkbox"/> Sinusitis 461.9   | 030 <input type="checkbox"/> Diabetes Type I 250.01                          | 077 <input type="checkbox"/> Mental Disorder 300.9   |
| 009 <input type="checkbox"/> Alzheimer's 331.0   | 031 <input type="checkbox"/> Diabetes Type II 250.02                         | 078 <input type="checkbox"/> Insomnia 780.52   |
| 010 <input type="checkbox"/> Poor Concentration/Memory 310.1                               | 029 <input type="checkbox"/> Hyperglycemia [high blood sugar] 790.29         | 079 <input type="checkbox"/> Mouth/Throat/Tongue   |
| 011 <input type="checkbox"/> Parkinson's Disease 332.0                                     | 048 <input type="checkbox"/> Hypoglycemia [low blood sugar] 251.2            | 080 <input type="checkbox"/> Canker Sores 528.2  |
| 012 <input type="checkbox"/> Anemia 285.9  | 049 <input type="checkbox"/> Dizziness/Balance Problem 780.4                 | 081 <input type="checkbox"/> Overweight 278.02   |
| 013 <input type="checkbox"/> Arthritic Disorder 716.90                                     | 050 <input type="checkbox"/> Ear Infection 381.4                             | 082 <input type="checkbox"/> Underweight 783.22  |
| 014 <input type="checkbox"/> Osteoporosis 733.00   | 051 <input type="checkbox"/> Epstein Barr 075                                | 083 <input type="checkbox"/> Sexual Disorder 302.89  |
| 015 <input type="checkbox"/> Asthma 493.90   | 052 <input type="checkbox"/> Eye Problems 379.91                             | 084 <input type="checkbox"/> Spinal Problems 724.9   |
| 016 <input type="checkbox"/> Emphysema 492.8   | 053 <input type="checkbox"/> Cataracts 366.9                                 | 085 <input type="checkbox"/> Obesity 278.00  |
| 017 <input type="checkbox"/> Cancer  | 054 <input type="checkbox"/> Glaucoma 365.9                                  | 086 <input type="checkbox"/> GERD 530.81   |
| 018 <input type="checkbox"/> Breast 174.9female 175.9male                                  | 055 <input type="checkbox"/> Macular Degeneration 362.50                     | 087 <input type="checkbox"/> HIV 042   |
| 019 <input type="checkbox"/> Prostate 185  | 056 <input type="checkbox"/> Fever 780.6                                     | 088 <input type="checkbox"/> Crohn's Disease 555.9   |
| 020 <input type="checkbox"/> Lung 162.9  | 057 <input type="checkbox"/> Fibromyalgia 729.1                              | 089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1                                    |
| 021 <input type="checkbox"/> Colon and Rectal 153.9  | 058 <input type="checkbox"/> Gallbladder Disorder 575.9                      | 092 <input type="checkbox"/> Normal Pregnancy v22.2<br>**only applicable if currently pregnant |
| 022 <input type="checkbox"/> Skin 173.9  | 059 <input type="checkbox"/> Gout 274.9                                      | 093 <input type="checkbox"/> Shingles 053.9  |
| 023 <input type="checkbox"/> Leukemia w/o remission 208.90<br>Leukemia w/ remission 208.91 | 060 <input type="checkbox"/> Headaches 784.0                                 | 140 <input type="checkbox"/> Migraines 346.90  |
| 024 <input type="checkbox"/> Lymphoma, malignant 202.8                                     | 061 <input type="checkbox"/> Hearing Loss 389.9                              | 141 <input type="checkbox"/> Rheumatoid Arthritis 714.0  |
| 025 <input type="checkbox"/> Brain Tumor, malignant 191.9                                  | 062 <input type="checkbox"/> Infertility, male 606.9                         | 142 <input type="checkbox"/> Non-Systemic Lupus 695.4  |
| 027 <input type="checkbox"/> Anxiety Disorder 300.00                                       | 064 <input type="checkbox"/> Liver Disease 571.9                             | 143 <input type="checkbox"/> Multiple Sclerosis 340  |
| 028 <input type="checkbox"/> Autism 299.00   | 065 <input type="checkbox"/> Hepatitis 573.3                                 | 144 <input type="checkbox"/> ALS (Lou Gerigs) 335.20   |
| 033 <input type="checkbox"/> Edema 782.3   | 066 <input type="checkbox"/> Hepatitis B 070.30                              | 145 <input type="checkbox"/> Polymyalgia Rheumatica 725  |
| 034 <input type="checkbox"/> Eczema 692.9  | 067 <input type="checkbox"/> Hepatitis C 070.51                              | 146 <input type="checkbox"/> Scleroderma 710.1   |
| 035 <input type="checkbox"/> Chronic Fatigue 780.71  | 068 <input type="checkbox"/> Kidney Disorder 593.9 or Bladder Disorder 596.9 | 171 <input type="checkbox"/> Goiter 240.9  |
| 036 <input type="checkbox"/> Circulatory Disorder 459.9                                    |  | 178 <input type="checkbox"/> Raynaud's Syndrome 443.8  |
| 037 <input type="checkbox"/> Heart Disease 429.9   |  | 179 <input type="checkbox"/> Hemochromatosis 275.0   |
| 038 <input type="checkbox"/> High Cholesterol 272.0  |  | 180 <input type="checkbox"/> Thalassemia 282.49  |
|  |  | 181 <input type="checkbox"/> Brain aneurysm 431  |

If necessary, please state your most significant concern...

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## General Health

- 100  Fingernail base is pink
- 101  Fingernail base is purple
- 102  Fingernails have ridges or white spots
- 103  Fingernails are soft
- 104  Fingernails are splitting
- 105  Fingernails peel
- 106  Pale fingernail beds
- 107  Blacks out easily
- 108  Balance problems
- 109  Difficulty walking
- 110  Has tattoos
- 111  Brittle hair
- 112  Dry hair
- 113  Thin hair
- 114  Hair loss
- 115  Drinks alcoholic beverages daily
- 116  Drinks less than 8 glasses of water per day
- 117  Currently on Chemotherapy
- 118  Currently on radiation treatment
- 148  Had radiation therapy in the last year
- 149  Had chemotherapy in the last year
- 119  Had chemotherapy in the past
- 120  Has had radiation treatments in the past
- 121  Gained over 20 lbs in the last 12 months
- 122  Somewhat Overweight
- 123  Somewhat Underweight

- 124  Unexplained weight loss of over 20lbs within the last 4 months
- 125  Energy level is worse than it was 5 years ago
- 127  Sleeps less than 6 hours per night
- 128  Unable to recall dreams the next day
- 129  Sensitive to chemicals, paint, fumes, cologne
- 130  Had blood transfusion in the past
- 131  Had transplant in the past
- 138  Takes anti-rejection drugs
- 132  Had a major accident or injury
- 137  Sleep Apnea
- 139  Toxic chemical exposure
- 175  Has been out of the country recently
- 176  Had childhood vaccines
- 177  Had a vaccine in the last 12 months
- 147  Had a flu shot last year
- 182  Had a pneumonia vaccine last year
- 183  Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:

- 184  Cancer
- 185  Heart Disease
- 186  Diabetes
- 187  Alcoholism
- 188  Depression
- 189  Obesity

## Lifestyle Habits

- 380  Drinks beverages from a can
- 370  Drinks alcohol
- 371  Drinks caffeinated coffee
- 372  Drinks caffeinated pop/soda
- 373  Drinks caffeinated tea
- 374  Drinks decaffeinated coffee
- 375  Drinks decaffeinated pop/soda
- 376  Drinks decaffeinated tea
- 377  Drinks more than 3 cups of coffee per day
- 378  Drinks more than 3 cups of tea per day
- 388  Drinks diet pop/soda

- 379  Drinks 1 or more pop/sodas per day
- I had 4 alcoholic drinks in one day:
  - 172  never
  - 173  more than 3 months ago
  - 174  less than 3 months ago
- 381  Has more than 5 alcoholic drinks per week
- 391  Craves sugar / starches
- 382  Currently smokes
- 383  Quit smoking in the last 5 years
- 384  Smoked for more than 5 years

- 385  Smokes more than 1 pack per day
- 126  Rarely exercises
- 133  Regularly exercises
- 386  Takes Vitamins
- 134  Vegetarian
- 135  Eats no red meat
- 136  Eats no meat, no dairy
- 387  Frequent use of artificial sweeteners
- 389  Anorexia
- 390  Bulimic

## Surgeries

- 700  Tonsillectomy and/or Adenoids
- 701  Appendix
- 702  Gallbladder
- 703  Thyroid

- 715  Radiated thyroid
- 708  Cancer
- 704  Hysterectomy, complete
- 705  Hysterectomy, partial

- 706  Tubal ligation
- 707  Breast implants
- 709  Coronary by-pass
- 710  Spinal surgery

- 711  Extremity surgery
- 712  Hip replacement

- 713  Knee replacement
- 714  Splenectomy

- 716  Cataract surgery
- 717  Hemorrhoidectomy

## Gastrointestinal

- 265  4-5 bowel movements per week
- 266  3 or less bowel movements per week
- 267  6 or more bowel movements per week
- 268  Black tarry stools
- 269  Pale or yellow colored stool
- 270  Blood stools
- 271  Constipation
- 272  Hemorrhoids
- 273  Loose bowel movements
- 274  Frequent diarrhea
- 275  Frequent nausea
- 276  Frequent vomiting
- 277  Abdominal gas
- 278  Belching and burping after eating
- 279  Bloating after eating
- 280  Severe abdominal pains
- 281  Stomach ulcers
- 282  Uses digestive aids
- 283  Uses laxatives

- 284  Immediate indigestion upon eating
- 285  Indigestion in 2 hours or more after meals
- 286  Indigestion within 1 hour after meals
- 287  Difficulty swallowing
- 288  Eating relieves fatigue
- 289  Eats when nervous
- 290  Excessive hunger
- 291  Poor appetite
- 292  Experiences fainting spells when hungry
- 293  Feels shaky when hungry
- 294  Frequently drowsy after eating a meal
- 295  Gall bladder disease
- 296  Has had intestinal worms
- 297  Reflux/Hiatal hernia
- 298  Liver disease
- 299  Irritable Bowel Syndrome
- 300  Diverticulitis
- 301  Diverticulosis

## Respiratory

- 485  Catches severe colds
- 486  Chronic chest condition
- 487  Chronic cough
- 488  Constant runny nose
- 489  COPD
- 490  Difficulty breathing

- 491  Frequent colds
- 492  Frequent nose bleeds
- 493  Frequent sinus infections
- 494  Frequent stuffy nose
- 495  Hay fever
- 496  Nasal polyps

- 497  Night sweats
- 498  Post nasal drip
- 499  Sneezing spells
- 500  Spits up blood
- 501  Spits up phlegm
- 502  Wheezes

## Mouth and Throat

- 400  Bad breath
- 401  Bitter taste in the mouth  
in the morning
- 402  Dry mouth
- 403  Excessive saliva
- 404  Sores or cracks in the  
corners of the mouth
- 405  Glands often swell
- 406  Frequent canker sores

- 407  Frequent fever blisters
- 408  Frequent sore throats
- 409  Frequently has a sore  
tongue
- 410  Sore gums
- 411  Swollen gums
- 412  Swollen tongue
- 413  Tongue burns

- 414  Tongue has grooves or fissures
- 415  Tongue is coated
- 416  Gums bleed when brushing teeth
- 417  Toothaches
- 418  Amalgam dental fillings
- 420  Other dental fillings  
(gold, composite, etc)
- 419  Has had root canal(s)

## Endocrine

- 245  Coarse hair
- 246  Coarse skin
- 247  Diabetic
- 248  Excessive thirst
- 249  Frequently feels cold
- 250  Frequently feels hot
- 251  Gets lightheaded when standing quickly
- 252  Heals slowly
- 253  Unusually jumpy or nervous
- 254  Unusually tired most of the time

## Cardiovascular

- 190  Cold feet
- 191  Cold hands
- 192  Experiences shortness of breath while sitting still
- 193  Heart skips beats
- 194  Tendency of High blood pressure
- 195  Leg cramps during bedtime
- 196  Leg cramps during daytime
- 197  Low blood pressure at times
- 198  Pain in leg/hips when walking
- 199  Frequent swollen ankles
- 200  Pains in the heart or chest
- 201  Spells of rapid heart rate
- 202  Troubled with blood clots
- 203  Unusually slow pulse rate
- 204  Varicose veins
- 205  Heart palpitations

## Skin

- 520  Bruises easily
- 521  Excessive perspiration
- 522  Frequent goose bumps
- 523  Has acne
- 524  Has Psoriasis
- 525  Hives
- 526  Itchy skin
- 527  Problems with Eczema
- 528  Has moles which are changing in size and/or color
- 530  Skin is rough, especially on the back of the arms
- 529  Skin eruptions
- 531  Skin is tender
- 532  Sores that heal slowly
- 533  Troubled with boils
- 534  Dry skin

## Ears

- 220  Discharge from ears
- 221  Hard of hearing
- 222  Punctured ear drum
- 223  Recurrent ear infection
- 224  Ringing or noises in the ears
- 225  Tinnitus

## Eyes

- 320  Bloodshot eyes
- 321  Blurred vision
- 322  Cross eyes
- 323  Eye pain
- 324  Eyes feel gritty
- 325  Eyes watery
- 326  Mild Glaucoma
- 327  Far sighted
- 328  Developing cataracts
- 329  Mild Macular degeneration
- 330  Itchy eyes
- 331  Near sighted
- 332  Dry Eyes

## Feet

- 350  Corns
- 351  Frequent foot cramps
- 352  Heel spurs
- 353  Painful feet
- 354  Plantar warts
- 355  Swelling in the feet and/or ankles
- 356  Plantar fasciitis
- 357  Fungal Infection

## Neuromuscular

- 440  Bites nails
- 441  Frequent muscle soreness
- 442  Muscle spasms
- 443  Muscle weakness
- 444  Tremors
- 445  Frequent headaches
- 446  Often dizzy
- 447  Frequently feels faint
- 448  Has Epilepsy
- 449  Has motion sickness
- 450  Has Osteoarthritis
- 451  Has Rheumatism
- 452  Rheumatoid Arthritis
- 453  Joint stiffness in the morning
- 454  Swollen joints
- 455  Leg pain at rest
- 456  Spinal curvature
- 457  Low back pain
- 458  Neck pain
- 459  Pain between the shoulders
- 460  Shoulder/arm pain
- 461  Numbness/tingling in the body
- 462  Sleep walks
- 463  Stutters or stammers
- 464  Nerve pain

## Behavior Patterns

- 150  Afraid to eat anywhere except home
- 151  Always needs someone to advise
- 152  Cries often
- 153  Difficulty concentrating
- 154  Difficulty falling asleep
- 155  Difficulty staying asleep
- 156  Easily angered
- 157  Feelings are easily hurt
- 158  Frequently becomes scared for no reason
- 159  Frequently miserable or blue
- 160  Has to be on guard even with friends

- 161  Often annoyed by people
- 162  Recurrent bad dreams
- 163  Sometimes wishes to be dead or away from it all
- 164  Upset by criticism
- 165  Poor memory
- 166  Scared to be alone
- 167  Strange people or places cause fear
- 168  Under considerable emotional stress
- 169  Unhappy when other are happy
- 170  Brain fog

## Urinary

- 555  Urinates more than 2 times per night
- 556  Bed wetting
- 557  Blood in the urine
- 558  Difficulty starting urination
- 559  Painful urination
- 560  Frequent urination

- 561  Troubled by urgent urination
- 562  Incontinence when sneezing or laughing
- 563  Loses bladder control
- 564  Frequent bladder infections
- 565  Frequent kidney infections
- 566  Kidney stones

## Men Only

- 585  Difficulty completing intercourse
- 586  Difficulty getting or keeping an erection
- 587  Discharge from the urethra
- 588  Had a vasectomy
- 589  Had difficulty fathering children
- 590  Lumps in the testicles

- 591  Painful genitals
- 592  Prostate troubles
- 593  Sores on external genitalia
- 594  Herpes
- 595  Sexual diseases

## Women Only

- 610  Heavy hair growth on face or body
- 611  Cycles are every 27-29 days
- 612  Abnormal cycle >29 days and/or <26 days
- 613  PMS
- 614  Menstrual cramps
- 615  Painful periods
- 616  Acne worse at menstruation
- 617  Excessive menstrual flow
- 618  Retains fluid during periods
- 619  Pre-menstrual depression
- 620  Currently taking birth control medication
- 621  Has taken birth control medication more than 1 year
- 622  Has taken birth control medication within the last year
- 623  Has had miscarriage
- 624  Hot flashes
- 625  Takes hormone replacement medication
- 627  Diminished sexual desire
- 628  Painful intercourse
- 629  Poor or infrequent orgasm

- 630  Lumps in the breasts
- 631  Tender breasts
- 633  Vaginal discharge
- 634  Bloody spotting discharge
- 635  Yeast infections
- 636  Sores on external genitalia
- 637  Herpes
- 638  Sexual diseases
- 639  Endometriosis
- 640  Breast reduction
- 641  Breast augmentation
- 642  Abortion
- 643  D&C
- 644  Tubal pregnancy
- 645  Uterine fibroids
- 646  Ovarian fibroids
- 647  Breast fibroids
- 648  Currently Breastfeeding

## Medications

**Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.**

| <b><u>DRUG</u></b> | <b><u>PRESCRIBED FOR:</u></b> | <b><u>HOW LONG</u></b> |
|--------------------|-------------------------------|------------------------|
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |

**Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.**

| <b><u>DRUG</u></b> | <b><u>PRESCRIBED FOR:</u></b> | <b><u>HOW LONG</u></b> |
|--------------------|-------------------------------|------------------------|
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |
| _____              | _____                         | _____                  |

**Please list any allergies (ex. foods, medications, etc.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.**

**VITAMIN/HOW MUCH/BRAND:**