Patient History Update:

Patient Name:_____ Date:_____ Date of Birth:_____

Language: English □ Spanish□ Indian □ Japanese □

Chinese □ Korean□ French □ German □ Russian □ Other □

Race: White □ American Indian or Alaska Native □ Asian □ Hispanic or Latino □

Native Hawaiian/other Pacific Islander □ Black or African American □

Ethnicity: Hispanic or Latino □ Not Hispanic or Latino □ Decline to Answer □

Are you seeing anyone else for other problems or health conditions? Yes□ No□

Please list the problem, date the problem began and provider treating you for this condition:

_____

_____

Past health history:

If yes, Include date & provider seen

Have you been diagnosed with Hypertension? Yes□ No□ _____

Have you been diagnosed with Diabetes? Yes□ No□ _____

Type I_____ Type II_____

Vitals:

What is your usual blood pressure?_____

Height?_____Weight?_____

**If you are unsure, please let us know so that we can take it for you*

Medications: (What Medications are you currently taking? Include vitamins, herbs, minerals. List date started, brand name, generic name, strength, dosage, quantity, refills available, prescribed by. Please be as specific as possible)

_____

_____

Do you have any allergies? □ Food □ Environmental □Medication

List types of allergy reaction:_____

Do you Smoke? □Never □Former smoker □Current/every day smoker

□Current some day smoker