Dr. Diane Grise
4535 S Lakeshore Dr., Ste 2
Tempe, AZ 85282

Date:_____

Patient Name:_____ Age:_____

Date of Birth:_____ Ethnicity:_____ Height:___ Weight:___

Gender: Female Male Other If other, please specify _____

Sex: Female Male Other If other, please specify _____

Preferred pronoun: He She They Other If other, please specify _____ #Children:____

Relationship Status:_____ If in a relationship, #years:____ Partner/Spouse's Name:_____

Occupation: _____ Employer:_____

Highest level of education:

Address:_____City:_____State:____Zip:_____

Home Phone: _____ Cell Phone:_____
OK to leave a message? Y N OK to leave a message? Y N

Work Phone: E-mail:

Person to Contact in Case of Emergency:_____

Relationship to Patient:_____

Phone:

How Did You Hear About Me?
□ My Website □ Other Practitioner Who? _____
□ Internet Search □ Current Patient Who? _____

Insurance Company: _____ __ PPO __ HMO
Primary Care Doctor: _____
Pharmacy # (if use specific pharmacy regularly): _____

If patient is a Minor, Name of Parent/Guardian(s)

_____

HEALTH CONCERNS

Please list your current health concerns in order from most bothersome to least bothersome. Please include mental, emotional, and physical concerns.

1) _____
2) _____
3) _____
4) _____
5) _____

HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES

	Date	Condition or Procedure
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

MEDICATIONS

Please list the medication and dosages that you are currently taking.
Please include both prescription and over the counter.

	Medication	Condition Treated	Dosage
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

SUPPLEMENTS

Please list all of the supplements that you are currently taking including dosages and brand names.

Supplement	Dosage	Brand

ALLERGIES

Please list any medication, food, environmental, or other allergies:

_____

_____

FAMILY HISTORY

	Children	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents
Alcoholism/Addiction						
Allergies						
Alzheimer's Disease						
Anemia/Clotting disorder						
Anxiety Disorder or OCD						
Arthritis						
Asthma						
Birth Defect: _____						
Cancer:_____						
Cancer:_____						
Cancer: _____						
Depression or Bipolar						
Diabetes						
Epilepsy/Seizures						
Gallbladder Disease						
Heart Attack						
High Cholesterol						
High Blood Pressure						
Hypoglycemia						
Kidney Disease						
Liver Disease						
Migraines						
Stroke						
Thyroid disease						
Tuberculosis						
Other:						
Other:						
Other:						

SOCIAL HISTORY

Type of Exercise	# min.	Frequency

Do you always eat breakfast? Y/N Lunch? Y/N Dinner? Y/N

Fresh vegetable intake: Twice or more/day Once/day Not daily Rarely

Fast food intake: 1+ times/day 1+ times/wk. 1+ times/mo. Rare Never

Daily water intake in cups: _____ Source: RO Tap Filter Well

Coffee/tea	Y N	#cups/day:	regular / decaf
Soda	Y N	#cups/day:	regular / diet
Alcohol	Y N	#___ drink(s) every _____	
Cigarettes/ Chewing	Y N Past	#pk/day	#yrs
Recreational Drug Use	Y N Past Rehab? Y N	Drugs Used:_____ _____	

What are your greatest sources of stress? (past or present)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What do you do for stress relief?

_____
_____
_____
_____
_____
_____

Active spiritual practice?

_____
_____
_____
_____
_____

NOW	PAST	GENERAL SYMPTOMS
		Tired, weak, lack of energy
		Depression, moodiness
		Worry, anxiety, nervousness
		Sleeplessness or too much sleep
		Frequent colds or other illnesses
		Headaches, migraines
		Dizziness, fainting, blacking out
		Cannot sweat/ too much sweat/ night sweats

NOW	PAST	EARS
		Earaches
		Noises or ringing in ears
		Ear discharges
		Loss of hearing
		Excess earwax
		Difficulty hearing

NOW	PAST	SKIN & HAIR
		Acne or pimples
		Hives, rashes
		Stretch marks
		Skin ulcers or sores
		Dryness, roughness or scaling skin
		Hair loss or thinning
		Dry, course hair
		Bruise easily
		Nails weak, ridged or split easily
		Brown spots or bronzing on skin
		Warts, moles or skin tags
		Sunburn easily
		Cuts heal slowly or scar badly
		Flush easily
		Athletes foot

NOW	PAST	GASTROINTESTINAL
		Loss of appetite
		Nausea or vomiting
		Bad breath
		Metallic or bitter taste in mouth
		Heartburn
		Indigestion
		Heaviness after eating
		Bloating or gas
		Belching
		Constipation
		Foul odor of stool or gas
		Diarrhea
		Light colored or greasy stools
		Undigested food in stool
		Blood in stool or on paper
		Hemorrhoids
		Rectal pain/itching
		Hepatitis A, B, or C

NOW	PAST	EYES
		Nearsightedness or farsightedness
		Blurred or failing vision
		Dry, burning or itching eyes
		Eyes water excessively
		Night blindness
		Bloodshot, red or puffy eyes
		Mucus or discharge in eyes
		Pain in eyes

NOW	PAST	CHEST
		Cough frequently
		Spitting up mucous or blood
		Difficultly breathing
		Chest pain
		Wheezing
		Palpitations

NOW	PAST	NOSE & THROAT
		Allergies, sinusitis, runny nose
		Dry mouth or nose
		Nosebleeds
		Cracks in corners of mouth
		Dry or chapped lips
		Sore throats or tonsillitis
		Sore, red, or cracked tongue
		Cold sores or herpes
		Loss of smell or taste
		Bleeding gums
		Hoarseness
		Grinding teeth
		Dental problems
		Difficulty swallowing

NOW	PAST	CARDIOVASCULAR
		Heart beats fast or irregularly
		Tightness in chest
		Discomfort in high altitude
		Dizzy or weak on standing
		Swollen feet, ankles or legs
		Cold hands or feet
		Hands or feet turn blue
		Leg pain with walking
		High blood pressure
		Low blood pressure

NOW	PAST	MUSCULOSKELETAL
		Muscle pain
		Weakness
		Joint pain (specify: _____)
		Joint swelling
		Back pain
		Neck pain
		Joint stiffness
		Numbness or tingling
		Decreased range of motion

NOW	PAST	FEMALE
		Irregular periods
		Pain prior to or with periods
		Depressed or irritable around periods
		Painful or swollen breasts
		Lumps in breast
		Nipple discharge
		Vaginal discharge
		Vaginal pain or itching
		Heavy periods
		Hot flashes
		Diminished or excessive sex drive
		Difficulty reaching orgasm
		Miscarriages (How many?_____)
		Abortions (How many?_____)
		Pain with intercourse
		Pelvic pain
		Inability to conceive
		Hormone replacement therapy

NOW	PAST	MALE
		Prostate problems
		Sexual difficulty
		Genital discharge
		Rashes or sores
		Pain in genitals
		Painful testicles
		Prostate problems
		Hormone replacement therapy

NOW	PAST	URINARY
		Difficulty urinating
		Urinate frequently at night
		Bed Wetting
		Incomplete urination or dribbling
		Pain when urinating
		Bladder or kidney infection
		Kidney stones
		Urine leakage
		Blood in urine

PAST MEDICAL CONDITIONS

Please check any conditions in your history:

	ADD/ADHD		Chemical Dependency		HIV Positive		Prostate Problems
	AIDS		Chicken Pox		Kidney Disease		Psoriasis/Eczema
	Alcoholism/Addiction		Depression/Anxiety/Bipolar		Leg Cramps		Psychiatric Hospitalization
	Allergies		Diabetes		Liver disease		Rheumatic Fever
	Anemia		Emphysema		Lyme Disease		Scarlet Fever
	Anorexia		Epilepsy		Measles		Sexual Abuse
	Appendicitis		Gall Bladder Disease		Migraine Headaches		Stroke
	Arthritis		Glaucoma		Miscarriage		Suicide Attempt
	Asthma		Goiter		Mononucleosis		Thyroid Condition
	Bleeding Disorder		Gonorrhea		Multiple Sclerosis		Tonsillitis
	Breast Lump		Gout		Mumps		Tuberculosis
	Bronchitis		Heart Disease		Pacemaker		Typhoid Fever
	Bulimia		Hernia		Physical Abuse		Ulcers
	Cancer: _____		Herpes (Oral / Genital)		Pneumonia		Vaginal Infections
	Cataracts		High Cholesterol		Polio		Venereal Disease

Check whether you have had the following screening tests, and whether they have been abnormal:			
Screening Test	Anything Abnormal?	Frequency of Screening	Last Test/Exam
General screening blood tests			
General physical exam			
Mammogram/breast imaging			
Colonoscopy			
Women's wellness exam			
Bone density test			
Prostate exam			

I certify that the above information is correct to the best of my knowledge.

Signature: _____ Date:_____

Print Name: _____