DR. LISA HUNT
AT VALLEY WELLNESS CENTER

A Medical Corporation
1300 Mable Ave., Suite C, Modesto, CA 95355
Phone (209) 577-2799 Fax (209) 571-1994

Integrative Medicine - Patient History

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: M / F (Circle)

Home Phone: _____ Business Phone: _____ Cell or Preferred Contact #: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Telephone: _____

Reason for visit: _____

Medications (Name, Dose, and Reason):

Current: _____

Past: _____

Medication Allergies: _____

Nutritional Supplements, Vitamins, Minerals: _____

_____

Surgeries: _____

Hospitalizations: _____

Past injuries or accidents (What & When): _____

_____

Do you or any family members have any of these illnesses?

High Blood Pressure: _____
Heart Disease: _____
Diabetes: _____
Thyroid Problems: _____
Depression: _____

Crohn's/Ulcerative Colitis: _____
Arthritis: _____
Asthma: _____
Fibromyalgia/Chronic Fatigue/Mono: _____
Alzheimer's/Dementia: _____

Mental Illness: _____ Anemia: _____
Epilepsy (Seizure): _____ Liver Disorder: _____
Parkinson's _____ Sexually Transmitted Disease: _____
Obesity: _____ Kidney Disorder: _____
Tuberculosis: _____ Urinary Disorder: _____
Hepatitis: _____ Addiction: _____
Gout: _____ Allergies: _____
Cancer: _____ Sleep Disorder: _____
Auto-immune (Lupus, Rheumatoid Arthritis, etc.): _____
Osteoporesis/Osteopenia: _____

Lifestyle Habits (please list if appropriate how much/day):

Alcohol: _____ Caffeine: _____ Tobacco: _____

Nutrition: Please list what a typical meal consists of:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Dessert: _____

Beverages (including how many cups/ounces per day you drink): _____

Any known food sensitivities: _____

Any food cravings (types): _____

Exercise:

Type: _____

Times per week: _____ Duration of Workout: _____Do you break a sweat? _____

Women's Health:

Date of last menstrual period: _____ PMS symptoms: _____

Contraception (if any list method): _____ Vaginal Discharge: _____

Menopausal/Menstrual cycle systems: _____

Last Pap: _____ Any abnormal Pap's: _____

STD History: _____