



Abundant Life Health Care

The complete balance of health, energy & wellness you can trust.

1617 W. Jefferson, Boise, Idaho 83702 (208) 433-9188 ph. (208) 433-9372 fax

Name: _____ DOB: _____

Social History:

Marital Status: Married Single Divorced Widowed

Tobacco Use: None Chewing tobacco Cigar/ Pipe

Cigarettes _____ packs/day for _____ years - quit date _____

Alcohol Use: None Type of drink _____ #drinks/week _____

Recreational Drug Use: Type of drug _____ #times/week _____

Exercise: Daily Weekly _____ #times/week Aerobic Weight Training

Intensity: Low Medium High

Seat Belt Use: Yes No Helmet or other safety measures: Yes No

Immunizations/ Screening Exams: (date of most recent)

hepatitis B _____ Pneumovax _____ tetanus _____ flu shot _____

stool-blood _____ chest x-ray _____ TB test _____ colonoscopy _____

Women ONLY:

Last Pap Smear _____ Any Abnormal Pap Smears? Yes No

Last Mammogram _____ Any Abnormal Mammograms? Yes No

Do you perform Breast Self-Exams? Yes No If Yes, how often? _____

Age you started your periods: _____ Are they regular? Yes No Number of Days _____

Do you still have periods? Yes No -Ever taken hormone replacement therapy? Yes No

Have you had bone density testing? Yes No

If Yes, when and where was most recent: _____

How many times have you been pregnant? _____ How many children do you have? _____

Number of vaginal deliveries: _____ Number of C-Sections? _____

Current Birth Control Method: _____ Not Applicable

Men ONLY:

Last Prostate Exam: _____ Any Abnormal Prostate Exams? Yes No

Last Testicular Exam: _____ Do you perform testicular self-exams? Yes No

Additional Information:

Name: _____ DOB: _____

Personal Health History: Do you have, or ever had any of the following? **Check all that apply.**

- Allergies Bowel Problems Heart Problems Migraine Headaches
- Anemia Breathing Problems High Blood Pressure Nerve Problems
- Alcohol/drug Cancer _____ High Cholesterol Seizures
- Arthritis Depression Insulin Resistance Skin Problems
- Asthma Diabetes _____ Kidney Problems Stroke
- Back Pain Eye Problems Liver Problems Thyroid Problems
- Blood Transfusion Serious Injury _____ Ulcers

Current Medications: Please include Prescription and OTC (over the counter) medications.

Name of Medication:	Dosage:	Taken how many times/day:

Medication Allergies: None Yes/List _____

List Any Hospitalizations or Surgeries:

Year:	Procedure/Reason:	Doctor:	Hospital:

Family History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Current age:						
Age at Death:						
Cause of Death:						
Heart Disease:						
High Blood Pressure:						
Stroke:						
Cancer/Type						
Glaucoma						
Diabetes/Epilepsy:						
Bleeding Disorder:						
Kidney Disease:						
Thyroid Disease:						
Mental Illness:						
Other:						