VillageGreen™ Apothecary

Health History Form

Name:_____ Date: _____

Address:_____

Home phone:_____ Work phone: _____ Cell phone: _____

E-mail address:_____

Age: _____ Date of Birth: _____ Place of Birth: _____

Gender: Female ____ Male ____ Height: _____ Weight: _____

Highest weight ever: _____ Year _____ Lowest weight as an adult: _____ Year _____

Where and when have you lived or traveled outside the U.S. and Canada? _____

_____

Are you currently receiving health care? Y N

If yes, where and from whom: _____

_____

If no, when and where did you last receive medical or health care?_____

_____

What was the reason? _____

What concerns would you like to address?	**How long have you had these conditions?**
1) _____	_____
2) _____	_____
3) _____	_____

In order to change these conditions, are you willing to make dietary and lifestyle modifications? Y N

Please list any other major health concerns past or present: _____

_____

What hospitalizations or surgeries have you had?

_____ Year: _____ _____ Year: _____

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart disease	High blood pressure	Kidney disease
Epilepsy	Arthritis	Glaucoma	Tuberculosis	Stroke
Anemia	Mental Illness	Asthma	Hay fever	Hives

What is your heritage? _____

Any other relevant family history? _____

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Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemical sensitivity? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

When during the day is your energy the best? _____ worst? _____

Do you exercise regularly? Y N List the types of exercise you get in a typical week:

Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping Pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or supplements you are taking.

Name	**Dosage / Frequency**	**Duration**

Additional things you want to mention or discuss:

_____
_____
_____
_____