LEXINGTON NATURAL HEALTH CENTER

PATIENT PROFILE DATE_____

The following information is critical to your health and Lexington Natural Health Center's treatment of you. Please take the time to fully and accurately fill out this form.

NAME_____ AGE_____ BIRTHDATE_____ SEX___

STREET_____CITY_____STATE_____ZIP_____HT_____WT_____

PHONE (home)_____(work)_____ SS#_____

Can we call you or leave a message at your home number? Y □ N □ Work number? Y □ N □

OCCUPATION_____EMPLOYER_____

E-MAIL (if you want to receive our newsletter & lecture notifications)_____

NAME IN CASE OF EMERGENCY_____PHONE#_____

How did you hear about our center?_____

Please list your primary care doctor on line one and any specialist you are seeing (line 2) and their location

1. Dr.'s Name_____Address_____Phone_____

2. Dr.'s Name_____Address_____Phone_____

_____

PRESENT HEALTH CONCERNS: Please list in their order of significance

1)_____

2)_____

3)_____

MEDICATIONS: (Please list current medications, including dosages)

_____

_____

SUPPLEMENTS (Please list current vitamins, herbs &/or homeopathic remedies, including dosages)

_____

_____ALL

ERGIES (Including medications, environmental &/or food)

_____

PAST MEDICAL HISTORY (Please check all relevant conditions)

Alcoholism		Epilepsy		Liver Disorder	
Allergies		Gout		Mental Illness	
Arthritis		Heart Disorders		Skin Disorder	
Asthma		Hepatitis		Stroke	
Cancer		High Blood Pressure		Thyroid Disorder	
Colitis		Hypoglycemia		Tuberculosis	
Diabetes		Injury (Serious)		Venereal Disease	

Others: _____

(OVER)

442 MARRETT ROAD, SUITE 8 LEXINGTON, MA 02421
TEL: 781-274-6190 FAX: 781-274-0356 WWW.LEXINGTONNATURALHEALTH.COM

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Date of last complete physical exam_____Date of last blood tests_____

Date/result of last Pap Smear_____Date/result of last bone density_____

Date/result of last mammogram _____Date/result of last colonoscopy_____

HOSPITALIZATIONS (Dates & type of illness/operation)

_____

SOCIAL HISTORY

Please circle those that apply: single married significant other

Do you have children? Yes No How many?_____ Ages_____

SAMPLE DIET: (Please be descriptive)

Breakfast_____

Lunch_____

Dinner_____

Snacks & Beverages _____

PERSONAL HABITS

Circle any of these substances that you use regularly: tobacco caffeine alcohol recreational drugs

Do you exercise regularly? If so, what type, how long & how often?_____

_____

Do you: Sleep Well? ____Y____N Wake rested? ____Y____N Average hours of sleep is _____

How many times do you wake up during the night?_____

REVIEW OF SYSTEMS: Besides your present health concerns, do you have any problems effecting your eyes, ears, nose, throat, sinuses, skin, blood, heart, lungs, stomach/intestines, kidney/bladder, nervous system, reproductive system, joints or glands? _____

FAMILY HISTORY

	Y	Who		Y	Who		Y	Who
Alcoholism			Epilepsy			Mental Illness		
Allergies			Gout			Osteoporosis		
Arthritis			Heart Disease			Skin Disorder		
Asthma			Hepatitis			Stroke		
Cancer			Hypertension			Thyroid Disease		
Colitis			Hypoglycemia			Tuberculosis		
Diabetes			Liver Disease			Venereal Disease		

I acknowledge that this information is true and correct to the best of my knowledge. I will notify Lexington Natural Health Center, Inc (LNHC) of any changes in my health status or above information.

I, the undersigned, am directly responsible for all payments for fees incurred on my behalf at this office. These are due and payable at the time services are rendered. If I do not meet my obligation of timely payments, I further understand that a late charge will be added to any overdue balance. If the account is not paid within 90 days of the date of service I understand I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting my account. I am aware that my practitioner may charge for telephone consultations and charge accordingly for office visits that extend past the time the office visit has been originally booked. I understand that the payment provided for consults with LNHC is nonrefundable.

Date_____ Signature_____Printed Name_____

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