Calmglow
FUNCTIONAL MEDICINE

209.247.9170
calmglow.com

History

Date of Visit

Patient Name | Email Address

Address | City | Zip

Home Phone | Cell Phone

Date of Birth | Age | Gender ❑ F ❑ M

Primary Care Provider Name

Last Mammogram | Last Physical | Pap Smear

Reason for Visit

Past Medical Diagnosis

Surgeries

Allergies

Medications

Supplements

Social History

Marital Status | Children | Occupation

If yes on any of the following, please write the amount per week.

Smoker ❑ Y ❑ N _____ | Adequate Sleep _____hrs | Caffeine ❑ Y ❑ N _____ | Alcohol ❑ Y ❑ N _____

Fast Food ❑ Y ❑ N _____ | Street Drugs ❑ Y ❑ N _____ | Violence ❑ Y ❑ N | Stress ❑ Y ❑ N _____

List Your Greatest Desires

My Desires Are Being Prevented By

Family History

If yes on any of the following, please write how that person relates to you.

Breast Cancer ❑ Y ❑ N | Gyn Cancer ❑ Y ❑ N

Colon Cancer ❑ Y ❑ N | Heart Disease ❑ Y ❑ N

Diabetes ❑ Y ❑ N | High Blood Pressure ❑ Y ❑ N

Thyroid Disease ❑ Y ❑ N

Other

The above information is accurate. I have had a mammogram within 1 year and a pap smear within 3 years. I release Calmglow from responsibility for adverse events.

Signature | Provider Signature