ALIST WELLNESS CENTER LLC

25 EAST WILLOW ST
MILLBURN, NJ 07041

HEALTH HISTORY

Name: ____
(Last Name) (First Name)

Reason for Visit: ______________________________Date:____________

Please indicate if you are having any current problems signs or symptoms:
Please put an X beside that is currently a problem. Put P beside a past problem:

Alcoholism	____	Immunosuppressant	____
Arthritis	____	Infectious Diseases	____
Blood Clots	____	Ulcers	____
Bursitis	____	Migraine Headaches	____
Cancer	____	Muscle Pains	____
Circulatory Problems	____	Pregnant	____
Diabetes	____	Parasites	____
Digestive Problems	____	Recurrent Infections	____
Drug Addiction	____	Respiratory Problems	____
Do you smoke	____	Skin Problems	____
Do you drink alcohol	____	Spinal Injuries	____
Contact lenses wear	____	Sinus problems	____
Epilepsy	____	Tuberculosis	____
Joint Pain	____	Tumors	____

GENERAL: Height____ Weight____ History of high blood pressure? Yes ___No____

Please list any medications that you are currently taking: ____________________________

Please list any supplements that you are currently taking: ____________________________

List of all surgeries within the last 5 years____

Do you have any allergies? (Include foods & medications):__________________________

Exercise (type and frequency) ____

Please list any information about your health in which you feel we should know:

____

What do you hope to achieve for this appointment? _______________________________