ReNew Medical Center
hA^{2}cg Patient Health Record

***Today's Date*:___/____/_____**

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Insurance ☐ Google/Internet ☐ Social Media ☐ Postcard ☐ Other _____

Patient Information

Last:_____ **First:**_____ **Middle:** _____

Allergies (foods, medicines, other): _____

Birth Date: ____/____/_____ **Age:**_____ **Sex:** ☐**M** / ☐**F** **Email Address:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Emergency Contact

Last:_____ **First:**_____**Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Weight Loss Goals

What are your weight loss goals? _____

Primary Doctor Information

Name: _____ **Phone:** (_____) _____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Illness(es): Current health conditions. Check all CURRENT conditions.

☐ Weak/compromised immune system
☐ Graves Disease
☐ Currently on Chemotherapy
☐ Hypotension
☐ History of Heart Issues
☐ Type 1 or uncontrolled diabetes
☐ Hypertension w/2 or more meds
☐ Cancer not in remission
☐ Unstable Gout
☐ Pregnant or Nursing
☐ Tuberculosis
☐ Gallbladder colic
☐ Unstable Angina

☐ Controlled Diabetic
☐ Anxiety/Depression
☐ Electrolyte Imbalance
☐ Hypothyroid
☐ Recovering alcoholics/addicts
☐ Dehydration Issues
☐ Stable Hypertension
☐ Cardiac Arrhythmia

Patient Name: _____ Date:_____

☐ **alzheimers**	☐ **cystic kidney disease**	☐ **multiple sclerosis**
☐ **anemia**	☐ **eczema**	☐ **parkinson's disease**
☐ **arthritis**	☐ **fibromyalgia**	☐ **pneumonia**
☐ **asthma**	☐ **hepatitis**	☐ **psoriasis**
☐ **cerebral palsy**	☐ **influenzal pneumonia**	☐ **seizures**
☐ **chicken pox**	☐ **liver disease**	☐ **STD's (unspecified)**
☐ **crohn's/colitis**	☐ **lung disease**	☐ **suicide attempt(s)**
☐ **CRPS (RSD)**	☐ **lupus erythema *(discoid)***	☐ **vertigo**
☐ **CVA (stroke)**	☐ **lupus erythema (systemic)**	☐ **other: _____**

Other Info:

Smoker: ☐Y/☐N How much? _____ Alcohol: ☐Y/☐N Drinks per week? _____

Recreational Drugs: ☐Y/☐N Type _____ Frequency _____

Coffee: ☐Y/☐N Cups per day _____ Sodas: ☐Y/☐N Type _____ Cans per day _____

Exercise: ☐Y/☐N Type _____ Frequency _____

Are you currently receiving any health care? ☐Y/☐N

What for? _____ From whom: Name _____

Address: _____ Phone: _____

I hereby acknowledge that the above information is true and correct to the best of my ability.

Print Name: _____ Signature: _____ Date: _____