

DOUBLE HAPPINESS HEALTH PATIENT INFORMATION

Last Name: _____ Date: _____

First Name: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Occupation: _____ Email Address: _____

Birthdate: _____ Height: _____ Weight: _____

Chief Reason for Visit: _____

Referred By: _____

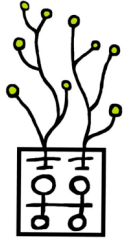
Emergency Contact (name and phone number) _____

Personal Medical History / Injuries / Surgeries (with dates)

CIRCLE any problems you've had:

Acute Hepatitis	High Blood Pressure	Irritable Bowel Syndrome
Chronic Hepatitis	Rheumatic Fever	Colitis
Eye Disease	Seizures	Ulcer
Gall Bladder Disease	Epilepsy	Other GI Disease
Other Liver Disease	Stroke	Sexually Transmitted Disease
Depression	Asthma	Specify: _____
Anxiety Disorder	Bronchitis	Thyroid Disorder
Other Psychological Disorder	Tuberculosis	Kidney Disease
Palpitations	Pneumonia	Meningitis
Heart Disease	Diabetes / Hypoglycemia	Cancer
		Specify: _____

Do you have any allergies? Y/ N Specify Allergens: _____



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Are you currently taking any prescription drug(s), herbs, vitamins, or other supplements? Y / N

Specify: _____

Describe your usage of the following:

Alcohol	Never	Rarely	1/month	1/Week	1/day	Often: _____
Tobacco	Never	Rarely	1/month	1/Week	1/day	Often: _____
Tea	Never	Rarely	1/month	1/Week	1/day	Often: _____
Coffee	Never	Rarely	1/month	1/Week	1/day	Often: _____
Soda	Never	Rarely	1/month	1/Week	1/day	Often: _____
Marijuana	Never	Rarely	1/month	1/Week	1/day	Often: _____
Other Recreational Drugs	Never	Rarely	1/month	1/Week	1/day	Often: _____

Describe any family history of illness:
