



Dr. Nate Greenstein
Patient Health History (1 of 2)

Please complete all pages of the health history form. Be as complete and accurate as possible. If something doesnot apply, put N/A for not applicable. **Please print or type.**

Name: _____ Date: _____

List the major health concerns in your order of importance. Describe each one in detail, as to its location, nature, and occurrence.

Describe the most significant measures taken-to-date to improve your health concerns including physicians seen, diagnostic tests performed, recommendations made and treatments rendered.

Concerning your past history, list, briefly describe, and give the dates of any major past illness, sickness, accident, injury, surgery, and dental work.

List and give the dosage of all prescription and non-prescription medications you are **currently taking**, when you started them, the reason for them, and the results.

List and give the dosage of all prescription and non-prescription medications you have **taken in the past**, when you started and stopped taking them, the reason for them and the results.

List the nutritional supplements you are currently taking, including the brand name, content and potency. Indicate the frequency which they are taken.



Dr. Nate Greenstein Patient Health History (2 of 2)

Rate your **current** stress level on a scale of 1 to 10. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe

Rate your stress level for the **past year**. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe

Rate your stress level for the **past five years**. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe

List the amount and type consumed or used for each of the following:

Water _____ Coffee _____ Tea _____
Soda _____ Alcohol _____ Tobacco _____

Are you on a special diet or have specific eating habits? No Yes

If yes, explain: _____

Indicate your current eating habits:

How many meals per day? _____ How many snacks per day? _____

What are your snacks? _____

Describe your average breakfast: _____

Describe your average lunch: _____

Describe your average dinner: _____

List the three **healthiest** foods you eat during the average week. _____

List the three **worst** foods you eat during the average week. _____

How many times a week do you eat fish? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat out? _____

Are you on an exercise program? No Yes

If yes, explain: _____

Do you wear: Orthotics No Yes

Heel lift No Yes

Special shoes No Yes

List and explain your family health history for all current and past major health problems. (ex. heart disease, cancer)

How motivated are you in improving or overcoming your major health concerns? (Circle one number)

1 2 3 4 5 6 7 8 9 10
Not very Somewhat motivated Fairly motivated Very motivated Extremely motivated
motivated and expecting the Dr. Willing to accept responsibility for my own actions
to do all the work

What are your **expectations** with Dr. Greenstein?

What are your **reservations** with Dr. Greenstein?

Please read, sign and date the following:

I completed this health history to the best of my knowledge. It is considered up-to-date, factual and an accurate representation of my health. I will notify you of any future changes with my health history.

Patient/Legal Guardian: _____

Date: _____