*Please complete and return toWilliamsburg Drug Company 1302 Mt. Vernon Ave, Williamsburg, VA 23185 or info@williamsburgdrug.com one week prior to your scheduled blood draw date.

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Health History Form

Name:_____ Date of Birth:_____ Date: _____

Address:_____

Phone:_____ E-mail address:_____

Gender: Female_____Male_____ Height:_____Weight: _____

Highest weight ever:_____Year_____ Lowest weight as an adult:_____Year _____

Do you have a Primary Care Provider? Y N

If yes, who is your Primary Care Provider?: _____

If no, when and what was the reason you last sought medical care?_____

_____

What concerns would you like to address?

☐ allergies	☐ thyroid (hypo/hyper)	☐ kidney disease
☐ headache	☐ diabetes (type I/type II)	☐ vitamin D deficiency
☐ fatigue	☐ heart disease	☐ high blood pressure
☐ weight gain	☐ menopause	☐ arthritis
☐ hormone imbalance	☐ high cholesterol	☐ mental illness
☐ anemia	☐ migraines	☐

In order to change these conditions, are you willing to make dietary and lifestyle modifications? Y N

Please list any other major health concerns past or present: _____

_____

What hospitalizations or surgeries have you had?

_____ Year:_____ _____Year: _____

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart disease	High blood pressure	Kidney disease
Epilepsy	Arthritis	Glaucoma	Tuberculosis	Stroke
Anemia	Mental Illness	Asthma	Hay fever	Hives

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Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemical sensitivity? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

When during the day is your energy the best?_____worst? _____

Do you exercise regularly? Y N List the types of exercise you get in a typical week:

Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____
Type of Exercise _____ How often _____ How long _____

Current Medications

Please list **any** prescription medications, over the counter medications, vitamins or supplements you are taking.

Name	**Dosage / Frequency**	**Duration**

Additional things you want to mention or discuss:

_____
_____
_____
_____