B.O.B.
Bio-Optimized Body
WELLNESS • BODY • MIND

Patient Health History Form

(Please acknowledge each section; simply put "N/A" if it does not apply)

Last Name:_____**First Name**:_____ **DOB**:_____

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

Email:_____**Phone**:_____

Primary Care Physician (Full Name): _____

Who referred you to us (Full Name):_____

Pharmacy Name: _____**City**: _____**Phone**: _____

Chief Complaint: What is the main reason for your visit today? Describe the problem in detail:

_____

_____

Past Medical History ☐ Denies Past Medical History

Check all that apply:

☐ Acid Reflux	☐ Congestive Heart Failure	☐ A.D.H.D./A.D.D.	☐ Crohn's Disease
☐ Alzheimer's Disease	☐ Anemia	☐ Asthma	☐ Bipolar Disorder
☐ Bleeding Disorder	☐ Blood Clots	☐ Cancer	☐ Cholesterol
☐ Concussion	☐ Diabetes-Type ____	☐ Digestive Problems	☐ Emphysema
☐ Gout	☐ Grave's Disease	☐ Heart Attack	☐ Heart Problems
☐ Hepatitis	☐ Herpes Zoster	☐ High Blood Pressure	
☐ HIV or AIDS	☐ I.B.S.	☐ Kidney Problems	☐ Leukemia
☐ Liver Problems	☐ Lung Problems	☐ Mental Illness	☐ Morbid Obesity
☐ Neoplasm, Benign	☐ Pneumonia	☐ Schizophrenia	☐ Seizures
☐ Sleep Apnea	☐ Stomach Ulcer	☐ Stroke	☐ Thyroid Disorder
☐ Tuberculosis	☐ Other: _____		

Previous Surgical History ☐ Denies any Past Surgeries

☐ Stomach ☐ Thyroid ☐ Heart ☐ Urology ☐ Breast ☐ Reproductive ☐ Vascular

☐ Colon ☐ Neuro ☐ ENT ☐ Other: _____

Family History ☐ Denies any Family Medical History

☐ Alcoholism ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Disorders ☐ Cancer_____

☐ Diabetes ☐ Gout ☐ Heart Problems ☐ Hypertension ☐ Kidney Problems

☐ Leukemia ☐ Mental Illness ☐ Musculoskeletal Diseases ☐ Respiratory Conditions

☐ Seizures ☐ Stroke ☐ Thyroid ☐ Other: _____

List all medications you are taking including vitamins or herbal supplements: ☐ None

_____

_____

List all known drug allergies: ☐ NKDA

_____

_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐ Domestic Partner
Work Status: Occupation: _____ ☐ Retired ☐ Unemployed ☐ Student
Are you Pregnant? ☐ Yes ☐ No
Work-related? ☐ Yes ☐ No Date: _____
Sports-related? ☐ Yes ☐ No Date: _____
Motor Vehicle Accident? ☐ Yes ☐ No Date: _____
Alcohol: ☐ No Alcohol ☐ Yes, daily (____ drinks/day) ☐ Yes, socially (____ drinks/week)
Tobacco: ☐ Never ☐ Currently (____ packs/day) ☐ Formerly
Drug overuse/abuse: ☐ Never ☐ Currently ☐ In the Past

How Did You Hear About Us? (Select all that apply):

☐ ER/Urgent Care (which one?): _____ ☐ Family/Friend:_____

☐ PCP _____ ☐ Other Provider_____ POSM Doctor_____

☐ POSM Website ☐ Google ☐ Bing ☐ Other Website_____ ☐ Social Media ☐ Magazine

☐ Community Event ☐ Sporting Event ☐ Other Event ☐ Saw the Building ☐ Southlake Chamber

☐ Irving Chamber ☐ Coppell Chamber

By signing below, I verify that the information provided is complete and accurate.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**