BRLL: New Patient Information/Health History

Please fill out this form to the best of your ability. I will review your responses before your first appointment.

First Name:

Last Name:

Birthdate:

Mobile Phone:

Other Phone:

Address:

Email address:

Preferred Pharmacy:

Please list any allergies to medications and your reaction to them:

Please list any environmental or food allergies:

List your current medications, including dose and how you take them:

List any current supplements, including dose and how you take them:

Please tell me when you last felt good and what has happened since then. Include any specialists you have seen, testing you have done, and treatments you have tried.

What is your occupation?

Do you exercise regularly?

Who lives with you?

What do you do for fun? What gives your life joy and meaning?

Do you have a strong support system?

Have you lived through trauma?

If I could erase 3 health problems, they would be:

EXPOSURES:

☐_ Tick bite(s)

☐_ Erythema Migrans (bullseye) rash

☐_ Cat scratches, bites, or high exposure to sneezing cats

☐_ Exposure to toxic metals (lead, mercury, etc)

☐_ Severe or prolonged mono

☐_ Repeated or prolonged use of antibiotics

☐_ More than 2 doses of steroids

☐_ Flooding or leaking at home or at work

☐_ Musty smell at home, in basement or at work

☐_ Symptoms increase or worsen at a specific location

FOOD HABITS:

☐_ I eat out a lot

☐_ I avoid gluten

☐_ I avoid dairy

☐_ I follow a paleo, autoimmune, ketogenic, or low histamine diet

☐_ I limit my diet because of food allergies or intolerances

☐_ I drink sweetened beverages most days

☐_ I do not eat green vegetables

OTHER HABITS:

☐_ I drink alcohol regularly

☐_ I use tobacco products

☐_ I vape tobacco/cannabis/other

☐_ I use my cellphone