DR. SUSAN MONIAS
Functional Healthcare
Customized for You

NEW PATIENT CONSULTATION FORM

PERSONAL INFORMATION

Full Name :

Today's Date :

Date of Birth : ____ Current Age : ____ Gender : ☐ Male ☐ Female

Address : ____

Mobile Phone : ____ Alternate Phone : ____

Email : ____

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnership

Spouse name : ____

Employer : ____

HEALTH HISTORY

- ☐ stroke
- ☐ heart attack
- ☐ diabetes type 1
- ☐ diabetes type 2
- ☐ thyroid disease
- ☐ gallbladder disease
- ☐ hypoglycemia
- ☐ depression
- ☐ high blood pressure
- ☐ mood swings
- ☐ stomach upset
- ☐ gout
- ☐ epilepsy
- ☐ kidney disease
- ☐ pacemaker
- ☐ organ transplant
- ☐ cancer
- ☐ intestine problems
- ☐ celiac disease
- ☐ chron's disease
- ☐ high cholesterol
- ☐ loss of balance
- ☐ tension
- ☐ heartburn
- ☐ headaches
- ☐ neck pain
- ☐ poor sleep
- ☐ dizziness
- ☐ arthritis
- ☐ mid-back pain
- ☐ lower back pain
- ☐ carpal tunnel syndrome
- ☐ fibromyalgia
- ☐ nervousness
- ☐ cold feet
- ☐ fatty liver

List any medications you are taking, and what they are for:

____

____

On a scale of 1-10, with 10 meaning "I'm serious about my health and fully committed", what is your current level of commitment? ____

Females:

Are you pregnant? ____

Are you breastfeeding? ____

Are you on birth control? ____

THANK YOU