Bereshit Lifestyle Center
3174 Riverdale Ave.
Bronx, New York 10463
Dr. Luis Rojas
Alternative and Holistic
Practitioner

PATIENT PROFILE

Name: _____ Date: _____

Age: _____ Birthdate: _____ Sex: F_____ M_____

Address: _____City: _____St:_____ Zip: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Full Time____ Part Time____

Retired____ In Case of Emergency Notify: _____

Relationship: _____ Address: _____

Phone #:_____ Family Physician:

_____ City: _____ Referred By:

Current Health Problems: _____

What are the most important health problems you would like to talk about today?

_____

_____

Health History: Check relevant areas and give brief details on the last page.

- ☐ Alcohol/Drug Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiovascular (heart) disorder
- ☐ Endocrine (gland) disorder
- ☐ G.I. (digestive) disorder
- ☐ Diabetes
- ☐ Gout
- ☐ Herpes Genitals
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Nervous System Disorders
- ☐ Psychological Problems
- ☐ Pulmonary (lung) disorder
- ☐ Injury (serious)
- ☐ Liver Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Venereal Disease

☐ Immune/Blood disorder ☐ Skin disorder

☐ Musculoskeletal disorder ☐ Urinary/Genital disorder

Other:

_____

_____

Hospitalizations: Dates and type of illness/injury/operation.

_____

_____

_____

_____

Medications and Supplements: Include prescription and nonprescription drugs, herbs, vitamins, minerals, etc.

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

HEALTH HABITS: Primary interests, hobbies or activities:

_____

Do you get regular exercise? Yes____ No____ If yes, in what form and how often?

_____

Do you drink alcohol? Yes____ No____ Use other recreational drugs? Yes____ No____

If yes to either question, how much, how often and what kind?

_____

Do you use tobacco? Yes____ No____ If so, what kind, how much and for how long?

_____

Do you drink coffee? Yes____ No____ If yes, how much?

_____

How many meals do you usually eat per day? _____ How many snacks? _____

What kinds of foods make up your usual diet? _____

_____
_____
_____

Family History: Check for blood relatives and list your relationship.

☐ Alcoholism	☐ Gout	☐ Sickle Cell Anemia
☐ Anemia	☐ Hay Fever	☐ Skin Disorders
☐ Asthma	☐ Heart Disease	☐ Stroke
☐ Hemophilia	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Hypoglycemia	☐ Tuberculosis
☐ Diabetes	☐ Mental Illness	☐ Venereal Disease
☐ Glaucoma	☐ Seizure or Epilepsy	

Other significant family health problems? _____
_____
_____

Female only:

Regular menstrual cycles: Yes____ No____

Average length of menstrual cycles (from period to period)? _____ Days.

Painful menstruation? Yes ____ No ____ Excessive flow? Yes ____ No ____

Prolonged flow? Yes ____ No ____ Premenstrual symptoms? Yes ____ No ____

Hysterectomy? Yes____ No ____ If yes, Total? _____ Partial? _____ When? _____

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you ever used birth control pills? Yes____ No____

If yes, when and for how long? _____

Please briefly explain any health history that you checked above:

_____
_____
_____
_____