FCI LABORATORIES

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HEALTH HISTORY

NAME:

ADDRESS:

CITY - STATE - ZIP:

HEIGHT: WEIGHT: AGE: SEX:

DATE OF BIRTH: PLACE OF BIRTH: RACE:

PHONE: E-MAIL ADDRESS:

NOTE: WE MAY NEED TO CONTACT YOU FOR ADDITIONAL INFORMATION. PLEASE PROVIDE EMAIL (PREFERRED) OR PHONE AND THE BEST TIME TO CALL

Reason:

Describe the main reason for seeking this health analysis, and what you hope to accomplish from the results:

Rate Your General Health:

(Excellent, Good, Fair, Poor) Describe any current symptoms you are experiencing:

Organs & Systems:

Describe any current and chronic problems you have with the different systems such as eyes, ears, nerves, digestive, etc. Include how long and what helps or aggravates the problem:

Bowel Movements:

List number of bowel movements daily:

Surgeries:

Please list all surgeries/organs removed. Reason and age:

Medications:

Describe all medications you are currently taking. Include prescription and non-prescription and the reason you are taking:

Vitamins/Supplements:

List all vitamins, minerals and supplements you take on a routine basis:

Emotional:

Please describe any emotional issues you are currently, or have experienced in the past: Include depression, anxiety etc:

Additional Information:

Use this area to list any information not covered in this questionnaire that you feel is relevant in formulating an overall health profile:
Disclaimer:
All testing conducted by FCI Laboratory is based on CLIA waived provisions and/or research based assessment, and is intended solely to assist the individual in determining health improvement strategies. FCI does not participate in insurance billing and you should understand that health improvement testing is not generally covered by insurance. The undersigned understands and agrees that any testing or recommendations made in conjunction with this laboratory testing is not intended to diagnose nor to provide treatment for any medical condition. The personal medical history information provided in this form is used solely to assist the laboratory in preparing such health improvement recommendations and for no other purpose. FCI does not participate in insurance billing, nor is alternative testing

Date: **Signature:**
Notice: Signature is required prior to completion of laboratory services