Salson Clinics LLC
1745 West 7800 South • West Jordan, Utah 84088
(801) 666-8640 • www.salsonclinics.com

Last Name: _____ **First Name:** _____
Date of Birth:

What is the main reason for your visit today?

List any allergies (Food or Medications):							
		Mild	Severe		Mild	Severe
		Mild	Severe		Mild	Severe
		Mild	Severe		Mild	Severe

List your medications:	**Dose: (MG., etc.)**	**Times per day**	(If you need more room to list, please write them on a blank sheet of paper.)
1)			
2)			
3)			
4)			
5)			

What is your occupation:?

Do you work the night shift? Yes No

Marital status: (Circle one) Single Partner Married Widowed Divorced

Do you have children? Yes No **How many?**

Do you smoke? YES Packs/day:____**for** ____years / **NO** Quit date: _____Pack/day: __

Do you drink alcohol? Yes No Beer Wine Liquor # of Drinks/week: _____

Do you use marijuana or recreational drugs? Yes No **Do you inject?** Yes No

Have you ever taken someone else's drugs? Yes No

Are you sexually active? Yes No **With:** Female Male

What is your birth control method?

Do you exercise regularly? Yes No

How would you rate your eating habits? Good Fair Poor

How well do you sleep? Good Fair Poor Hours per night _____

Have you traveled outside the country in the last 30 days? Yes No **Where?**

Have you served in the military? Yes No **Were you deployed?** Yes No **How Long?**

SCREENING TESTS	Facility:	Approx. Date:		
Cholesterol			Abnormal	Normal
Colonoscopy			Abnormal	Normal
Mammogram			Abnormal	Normal
Pap Smear			Abnormal	Normal
Bone Density			Abnormal	Normal

Vaccinations:	Date:		Date:
Covid			
Last Tetanus Booster or Tdap:		Last Pneumonia Vaccine:	
Last Flu Vaccine:		Last Shingles Vaccine:	

(check)		Current	Past		Current	Past
(check all that apply)	Alcoholism			Heart disease		
	Drug Use			High Blood Pressu		
	Asthma			High Cholesterol		
	Cancer			Thyroid Disease		
	Depression			Kidney Disease		
	Anxiety			Migraine Headach		
	Diabetes			Stroke		
	Emphysema (COPD)			Other:		

Surgeries:	Date:	Location / Facility

Women:	Date:		
Last Menstrual Cycle:		Age of 1st Menstruation :	
Age of Menopause:		Total # of pregnancies:	
Number of Live Births:		Complications:	

Family Health: (Check all that apply)	Alcohol / drug use	Asthma	Cancer: (Type)	COPD	Depression Anxiety	High Blood Pressure	Diabetes	Kidney Disease	High Cholesterol
Mother:									
Father :									
Brother:									
Sister :									
Grandprnt:									