MEDICAL HISTORY

NAME: ____________________

Do you have any of the following condition or have you had them in the past?

	NOW	PAST
Loss of Hearing		
Ringing In Ears		
Ear Infections		
Bad Vision		
Glaucoma		
Nose Bleeds		
Sinus Trouble		
Sore Throat		
Allergies		
Hoarseness		
Pneumonia		
Bronchitis		
Asthma		
Shortness of Breath		
Tuberculosis		
Heart Murmer		
Palpitations		
Irregular Pulse		
Swollen Ankles		
Chest Pain		
Loss of Appetite		
Indigestion		
Stomach Ulcers		
Diarrhea		
Constipation		
Bloody/Tarry Stools		
Hemorrhoids		
Hernia		
Gall Bladder		

	NOW	PAST
Sudden Weight Loss		
Liver Disease		
Back Pain		
Joint Pain		
Broken Bones		
Dizzy Spells		
Fainting Spells		
Memory Loss		
Insomnia		
Nervousness		
Depression		
Phobias		
Manic Depression		
Anxiety		
Schizophrenia		
Bulimia		
Anorexia		
Other Eating Disorders		
Frequent Urination		
Kidney Disease		
Kidney Stones		
Prostate Disease		
Headaches		
Migraines		
Fatigue		
Anemia		
Immune Disorders		
Alcohol Abuse		
Drug Abuse		

	NOW	PAST
Heart Disease		
Thyroid Disease		
Cancer		
Diabetes		
Stroke		
Osteoporosis		
Gerd		
Rashes		
Chicken Pox		
Mumps/Measles		
Polio		
Nausea		
Vomiting		
Stomach Ulcers		
Heartburn/Reflux		
High Blood Pressure		
High Cholesterol		
Hepatitis		
HIV/AIDS		
MRSA		
Seizure/Epilepsy		
Leg Cramps		
Gout		
Malaria		
Thyroid Fever		
Cholera		
Hypoglycemia		
Arthritis		

FAMILY HISTORY: IF A BLOOD RELATIVE HAS SUFFERED THE FOLLOWING, PLEASE INDICATE THE RELATIONSHIP

Heart Attack	
Cancer	
Hypertension	
Stroke	
Epilepsy/Seizures	
Arthritis	
Diabetes	
Obesity	
Glaucoma	
Other:	

Please list all other known chronic conditions or medical illnesses:

Please list any medication allergies below:

Medications:

Please list any medications you were prescribed or OTC that you take as needed or regularly take.

Any chance of pregnancy?
Are you breast feeding currently?

In the past year, have there been any changes in your family? Check all that apply.

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of job
- ☐ Birth
- ☐ Serious Illness
- ☐ Death
- ☐ Other
- ☐

Do you take: Check all that apply.

- ☐ Vitamins
- ☐ Laxatives
- ☐ Hormones
- ☐ Pain Medication
- ☐ Stomach Medication
- ☐ Birth Control Pills
- ☐ Nerve Condition Cold
- ☐ Medication Herbal
- ☐ Supplements

Please rate the intensity of any of these symptoms you have had in the past.

0 = NO PROBLEM 1 = MINOR PROBLEM 2 = BIG PROBLEM

- ☐ Hunger
- ☐ Cravings
- ☐ Mood Swings
- ☐ Irritability
- ☐ Headache
- ☐ Feeling "wired"
- ☐ Skin Rash
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hot Flashes
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Blurred Vision
- ☐ Excess Urination
- ☐ Rapid Heart Rate
- ☐ Palpitations
- ☐ Insomnia
- ☐ Anxiety
- ☐ Shortness of breath
- ☐ Difficulty urinating
- ☐ Excess thirst