Medical History

Patient Name: ___________________________________ Today's Date:________________

Please list any allergies (medications, food sensitivities, environmental, etc.) and describe reaction:

Please list any current medications with strengths and dosages:

Please list any current supplements/herbs with dosages:

Please list prior hospitalizations, major illnesses or accidents, or surgeries with approximate dates:

Please list approximate dates and results :

	Date	Results
PAP Smear		
Mammogram		
Bone Density Scan		
EKG / Stress Test		
Chest X-Ray		
Colonoscopy		
Blood Work		
Last Menstrual Period		

Family Medical History

Please indicate and identify if any family members have had any of the following conditions:

M = mother F = father B = brother S = sister G = grandparent C = your children

Allergies		Hearing Problems	
Alcoholism		High Blood Pressure	
Asthma		High Cholesterol	
Bleeding Tendency		Kidney Disorder	
Cancer		Low blood sugar	
Cardiovascular Disorder		Nervous system disease	
Depression/Mental Health		Thyroid Disease	
Diabetes		Tuberculosis	
Endocrine Problems		Other (describe)	

Symptom Checklist:

Have you ever experienced (Past) or do you suffer (Current) from any below?

	Past	Current		Past	Current
Alcoholism			Decreased Sex Drive		
Allergies			Depression		
Anemia			Diabetes		
Anxiety			Diarrhea		
Arthritis			Difficulty make Decisions		
Asthma			Difficulty Waking		
Back Pain			Dizziness		
Bad Breath			Disturbing Dreams		
Bloating/Gas			Dry Hair		
Blood Stool			Dry/Brittle Nails		
Blood Pressure			Dry Skin		
Brain Fog			Ear Ringing		
Bruise Easily			Enlarged Thyroid		
Bursitis			Eye Pain/Changes/Fatigue		
Cancer			Fluid Retention		
Chest Pain			Foot Pain		
Chronic Fatigue			Forgetfulness		
	Past	Current		Past	Current
Cold Hands/Feet			Frequent Colds		
Constipation			Frequent Urination		
Cough			Hay Fever		
Cramps			Headaches		
Craving for Salt			Heartburn/GERD		
Craving for Sweets			Heart Palpitations		
Hemorrhoids			Sinus Problems		

Hot Flashes			Skin Problems		
Insomnia			Sleepy After Meal		
Interrupted Sleep			Spine Issues		
Irregular Menses			Stroke		
Joint Pain			Tremor		
Kidney Pain/Infection			Tuberculosis		
Leg Pain			Ulcers/Herpes		
Lump in Breast			Vaginitis		
Mood Swings			Varicose Veins		
Nausea			Weight Gain		
Neck Pain			Weight Loss		
Night Sweats			Worry/Feel Insecure		
Nosebleeds			Yeast Infections		
Numb/Tingling					
Phlegm/Mucus					
Poor Circulation					
PMS					
Poor Digestion					
Prostate Issues					
Shortness of Breath					
Shakiness if Hungry					
Sciatica					
STD History					