

## PATIENT MEDICAL HISTORY

ID Number: \_\_\_\_\_

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

### MEDICAL HISTORY (Check the appropriate box)

		Your Family		Your Family
Have you or any members of your family had:	You		You	
1. High Cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Blood Transfusion.....	<input type="checkbox"/>
2. Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Allergies.....	<input type="checkbox"/>
3. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Breast Problems.....	<input type="checkbox"/>
4. High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Cancer.....	<input type="checkbox"/>
5. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Birth Defects or Inherited Diseases.....	<input type="checkbox"/>
6. Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Other Medical Problems.....	<input type="checkbox"/>
7. Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	21. No Known Medical Problems	<input type="checkbox"/>
8. Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Are You Pregnant.....	<input type="checkbox"/>
9. Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Do You Plan on Becoming Pregnant.....	<input type="checkbox"/>
10. Stomach, Bowel or Gall Bladder Problems.....	<input type="checkbox"/>	<input type="checkbox"/>		
11. AIDS (HIV).....	<input type="checkbox"/>	<input type="checkbox"/>		

### WEIGHT HISTORY (Answer to the best of your ability)

What was your weight:

In high school \_\_\_\_\_      When you got married \_\_\_\_\_      After Pregnancy (1) \_\_\_\_\_  
 After Pregnancy (2) \_\_\_\_\_      After Pregnancy (3) \_\_\_\_\_

**HOSPITALIZATIONS** (Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than five, check the box. )

Month/Year	Illness or Operation	Attending Physician's Name	Complications	
			Yes	No

<b>MEDICATIONS NOW TAKING:</b> Are you now taking any of the following:	<u>Yes</u>	<u>No</u>
1. Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Codeine/Demerol/Other Pain medicine.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Sedatives/tranquilizers.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Birth control pills.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Estrogens.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Other hormones.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Blood pressure or heart medicines.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Thyroid medication.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Other medicines/vitamins.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you allergic to or do you react poorly to any medicines? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you a habitual user of any medications or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you using prescription or over the counter diuretics? .....	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you take vitamin or mineral supplements? .....	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you take herbal supplements? .....	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you use topical creams, cleansers or moisturizers that contain hormones or oils? .....	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST MEDICATIONS YOU ARE NOW TAKING

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |