PATIENT MEDICAL HISTORY

Date: _____

Client Name: _____ DOB: _____

Address: _____

_____

Home Phone: (_____) _____ Cell Phone: (_____)_____

Primary Physician: _____ Phone: (_____)_____

Email: _____

MEDICAL HISTORY (Check the appropriate box)

Have you or any members of your family had:	You	Your Family
1. High Cholesterol……	□	□
2. Heart Disease……..	□	□
3. Diabetes…….……	□	□
4. High Blood Pressure…….	□	□
5. Asthma……...	□	□
6. Tuberculosis……	□	□
7. Rheumatic Fever……	□	□
8. Thyroid Disease…….	□	□
9. Liver Disease……..	□	□
10. Stomach, Bowel or Gall Bladder Problems…….....□		□

	You	Your Family
11. Blood Transfusion……	□	□
12.. Allergies…….	□	□
13. AIDS (HIV)……	□	□
14. Cancer…….	□	□
15. Birth Defects or Inherited Diseases……..	□	□
16. Other Medical Problems……	□	□
17. No Known Medical Problems	□	□

WEIGHT HISTORY (Answer to the best of your ability)

What was your weight:

In high school_____ After College_____

In Your 30's & 40's_____ In Your 50's-Present_____

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

MEDICATIONS NOW TAKING: Are you now taking any of the following:

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

PLEASE LIST MEDICATIONS YOU ARE NOW TAKING

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