MEDICAL HISTORY

NAME:_____ **BIRTHDATE:**_____ **Date:**_____

1.) May we discuss your medical care with anyone other than you? ☐ Yes ☐ No
If yes, who:_____

2.) Please list all current medications, including over the counter medications, home remedies, vitamins, etc.:_____

_____

3.) Major injuries, surgeries and/or hospitalizations: _____

_____

4.) Any known allergies?_____

5.) Do you currently have or have you chronically had any of the following:

Skin Problems	○	_____
Fever/Weight Loss/Gain	○	_____
Headaches/Migraines	○	_____
Seizures	○	_____
Thyroid Problems	○	_____
Allergies/Hay fever	○	_____
Chronic Cough	○	_____
Asthma	○	_____
Emphysema	○	_____
Diabetes	○	_____
High Blood Pressure	○	_____
Vascular Disease	○	_____
Diarrhea	○	_____
Constipation	○	_____
Kidney Problems	○	_____
Arthritis	○	_____
Anemia	○	_____
Psychiatric Problems	○	_____
Bleeding Problems	○	_____
Eye Problems	○	_____
HIV/AIDS	○	_____
Hepatitis	○	_____

5.) Family History: Please check all that apply to your family (parents, grandparent, siblings or children)

Disease / Condition:	**YES**	**Explain:**
Skin Disease	○	_____
Eye Problems	○	_____
Arthritis	○	_____
Cancer	○	_____
Diabetes	○	_____
Heart Disease	○	_____
High Blood Pressure	○	_____
Kidney Disease	○	_____
Thyroid Disease	○	_____