MEDICAL HISTORY

NAME_____DATE_____
OCCUPATION_____DOB_____REFERRED BY:_____

CURRENT MEDICAL CONDITIONS CHECK IF NONE_____

PRESENT MEDICATIONS AND DOSAGES CHECK IF NONE_____

PAST MEDICAL PROBLEMS & ILLNESSES CHECK IF NONE_____

DRUG ALLERGIES CHECK IF NONE_____

HOSPITALIZATIONS (EXCLUDE OPERATIONS) CHECK IF NONE_____

SURGERIES

___Hysterectomy	___Appendix	___Kidney
___D&C	___Hernia	___Vasectomy
___Cesarean	___Tonsils	___Thyroid
___Mastectomy	___Heart	___Cataract
___Tubal Ligation	___Ears	___Mouth
___Bladder	___Back	___Neck
___Gallbladder	___Knee	___Other _____

FAMILY HISTORY	RELATIONSHIP
___High blood pressure	_____
___Diabetes	_____
___Stroke	_____
___Colon cancer	_____
___Breast cancer	_____
___Prostate cancer	_____
___Arthritis	_____
___Heart attacks	_____
___Dementia (Alzheimers)	_____
___Emotional/Mental Illness	_____
___Obesity	_____
___Premature death	_____