

MEDICAL HISTORY

Patient's Name _____ Height _____ Weight _____

Name of Family Physician _____ Phone Number _____

Address _____

Do you take aspirin, ibuprofen or similar medications? Yes No

List Drug Sensitivities and/or allergies with reactions: None (circle if none)

Medications taken with dosage, including herbal medications and supplements: _____

Females: Are you currently pregnant? Yes No Last menstrual date? _____

List date(s) of childbirth(s) _____

List all previous surgeries with dates: _____

List all other hospitalizations with illnesses and year: _____

Do you smoke? Yes No How much? _____

Do you consume alcohol? Yes No How much? _____

If necessary, will you accept a blood transfusion? Yes No

Do you now or have you ever had:

Auto-immune (Lupus, Polyarteritis, etc.) Yes No

Anemia Yes No Chronic Pain Disorders Yes No Heart Disease Yes No

Arthritis Yes No Epilepsy or Seizures Yes No Easy Bruising Yes No

Asthma Yes No Immune disorder/ HIV Yes No Kidney Disease Yes No

Addiction Yes No High Blood Pressure Yes No Stomach Ulcers Yes No

Hepatitis Yes No Bladder infections Yes No Chronic Fatigue Yes No

Glaucoma Yes No Blood Clots in Legs Yes No Emphysema Yes No

Diabetes Yes No Counseling Yes No (if yes, see below)

Regarding Counseling: Counselor/Physician Name, Date, and Nature of Counseling

I attest that these statements regarding my medical history are true to the best of my knowledge.

Signature _____ Date _____