



Medical History

CONFIDENTIAL

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NAME (LAST, FIRST, MI)	DATE
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MAJOR COMPLAINT/HEALTH PROBLEM

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? YES NO	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT DID YOU RECEIVE?
WHAT WERE THE RESULTS OF THE TREATMENT?	

LIST ANY ALLERGIES:

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	# PER DAY	FOR HOW LONG?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD: DATE	SURGERY
_____	_____
_____	_____
_____	_____

LIST ANY SIGNIFICANT TRAUMAS (FALLS, AUTO ACCIDENTS, ETC.) DATE	INCIDENT
_____	_____
_____	_____

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	