MEDICAL HISTORY FORM

NAME _____ **AGE** _____ **DATE** _____

A. List past or present illnesses, injuries, surgeries, hospitalizations:

Condition	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. List any physical limitations:
_____

C. List allergies (i.e. hay fever, bee sting, foods, medications, molds, dust, animals, latex, etc.):
_____

D. Family History (i.e. premature sudden death, heart attack, stroke, diabetes, cancer, asthma, etc.):

Relation to You	Condition
_____	_____

E. Have you had any metal devices placed in your body (i.e. dental amalgams or restorations, prosthetic joints, IUD's, vascular stents) or have you ever reacted to any metal? Y N (If yes, please explain):
_____

F. Do you or have you used any of the following: (If yes, please include amount and how many years).

Cigarettes	Y	N	_____
Alcohol	Y	N	_____
Caffeine	Y	N	_____

G. Marital Status _____ Children _____ Occupation _____ Frequent travel Y N

H. Do you have, or have you ever sought medical care for any of the following:

Mental Health	No	Yes	Explain
Depression	___	___	_____
Insomnia	___	___	_____
Fatigability	___	___	_____
Eating disorders	___	___	_____
Other	___	___	_____
Head & Neck	**No**	**Yes**	**Explain**
Frequent headaches	___	___	_____
Chronic sinus	___	___	_____
Glasses/Contacts	___	___	_____
Hearing difficulty	___	___	_____
Sores of the mouth	___	___	_____
Root canal	___	___	_____
Other _____	___	___	_____

Lungs/Breathing	No	Yes	Explain
Wheezing	___	___	_____
Shortness of breath	___	___	_____
Chronic cough	___	___	_____
Asthma	___	___	_____
Heart & Circulation			
Chest pains	___	___	_____
Irregular heart beats	___	___	_____
Leg/feet swelling	___	___	_____
High blood pressure	___	___	_____
Exertional	___	___	_____
Heart murmur	___	___	_____
Digestive			
Recent weight changes	___	___	_____
Diarrhea/Constipation	___	___	_____
Nausea/Vomiting	___	___	_____
Jaundice (yellow skin or eyes)	___	___	_____
Kidney/Bladder Reproductive			
Abnormally colored urine	___	___	_____
Kidney disease	___	___	_____
Frequent urine infections	___	___	_____
Severe menstrual cramps	___	___	_____
Cancer			
Precancerous condition	___	___	_____
Cancer	___	___	_____
Hematological			
Blood Transfusions	___	___	_____
HIV, Hepatitis	___	___	_____
Bone/Joint/Muscle			
Hernia	___	___	_____
Carpal Tunnel Syndrome	___	___	_____
Joint pain/arthritis	___	___	_____
Strain/sprain	___	___	_____
Skin			
Rashes	___	___	_____
Other skin problems	___	___	_____
Neurologic			
Seizures	___	___	_____
Tremors	___	___	_____
Loss of consciousness	___	___	_____
Endocrine			
Diabetes	___	___	_____
Thyroid problems	___	___	_____
Unexplained weight changes	___	___	_____
Other glandular problems	___	___	_____

Patient Signature _____ Date _____