

Medical History

CONFIDENTIAL

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

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.....

HOW DID THIS CONDITION DEVELOP?

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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?

WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG
.....
.....
.....

LIST ANY MAJOR SURGERIES YOU HAVE HAD: DATE	PROBLEM/SURGERY
.....
.....
.....

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

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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	