Past Medical History

Please indicate if you have had any of the following problems in the past. Please note years affected.

Alcoholism _____
Allergies _____
Anemia _____
Arthritis _____
Asthma _____
Bleeding/Bruising _____
Cancer _____
Chemotherapy _____
Congenital Heart Defect _____
Crohn's/Colitis _____
Depression _____
Diabetes _____
Difficulty Breathing _____
Digestive Disease _____
Dizziness _____
Drug Problems _____
Eating Disorder _____
Heart Disease _____
Herpes _____
HIV _____
Hypoglycemia _____
Headaches _____
Heart Attack _____
Heart Murmur _____
Heart Surgery _____
Hepatitis _____
High Cholesterol _____
High/Low Blood Pressure _____
Irritable Bowel _____
Kidney Disease _____
Loss of Sleep _____
Low Back Problems _____
Lupus _____
Lyme Disease _____
Mental Illness _____
Migraine Headache _____
Multiple Sclerosis _____
Neck Pain _____
Numbness in Arms/Hands/ Legs/Feet _____
Pacemaker _____
Pain between shoulders___
Pneumonia _____
Polio _____
Psychiatric Problems _____
Rheumatic Fever _____
Sinus Problems _____
Shingles _____
Stroke/TIA _____
Seizures _____
Ulcers _____
Tuberculosis _____
Thyroid Disease _____
Venereal Disease _____

For Women:
Are you pregnant? Yes ___ No ___
Are you nursing? Yes ___ No ____
Are you taking birth control? Yes ____ No ____
Do you experience painful periods? Yes _____ No ____
Do you have irregular cycles? Yes _____ No ____
Do you have breast implants? Yes _____ No ____

Your Tests: Specify when, if known..
Last Physical Exam: _____
Chest X-Ray: _____
Neck/Lower Back X-Ray: _____
EKG: _____
Blood Tests: _____
Urine Tests: _____
Rectal Exam: _____
PAP Smear: _____
Breast Exam: _____

Immunizations: Specify when, if known

Smallpox: _____
Polio: _____
Measles/Mumps/Rubella: _____
Pertussis: _____
Diptheria: _____
Tetanus: _____
Influenza: _____
Hepatitis: _____
Chicken Pox: _____
HPV: _____
Other: _____

Hospitalizations/Surgeries: (Type and Date)
_____
_____
_____

Current Medications:
Please write name, dosage, frequency, and for what reason.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list any medications you may have an **allergy** to and the type of reaction.
_____
_____
_____

Over the Counter Medications: (Type and Frequency)
_____
_____

Nutritional Supplements: (Type and Frequency)
_____
_____
_____

Recreational Drug Use: (Type and Frequency)
_____
_____