MEDICAL HISTORY

PATIENT NAME________________________________ **PHONE#** (_____)_____________ **DATE**__________

DATE OF BIRTH___________________ **AGE**_______________ ☐ Female ☐ Male

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered Children? Ages ________________

Present Complaint in order of importance.	How Long D = days W = weeks Y = years	Relevant History of Complaint	Doctor Use Only
example: Headache	8-D	Since getting the flu	
1.			
2.			
3.			
4.			

LIST BELOW OR BACK OF THIS PAGE FOR OTHER PROBLEMS.

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____

CURRENT MEDICAL DRUGS:____

____

CURRENT NATURAL SUPPLEMENTS:____

____

HAVE YOU HAD ANY OF THESE CONDITIONS IN THE LAST 5 YEARS?

☐ Root Canals ☐ Eye Problems ☐ Recurrent colds ☐ Periodontal problems ☐ Asthma ☐ Chemical Allergen
☐ Arthritis ☐ Digestive Problems ☐ Food Allergies ☐ Tonsillitis ☐ Eczema ☐ Neck – Back Pain
☐ Hives/Rash ☐ Candida ☐ Ear problems ☐ Depression ☐ Hay Fever ☐ Other

Other____

OPERATIONS (include dental) + DATES

____

____

ACCIDENTS / MAJOR ILLNESS + DATES

____

FAMILY HEALTH HISTORY (Ailment)

Father____
Mother____
Brother____
Sister ____

Allergies – FOOD &/or ENVIRONMENTAL

____

____

____

Are you allergic to any antibiotics &/or medications?

☐ Yes ☐ No If yes, what?

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YOUR PRIMARY DOCTORS

MD/DO____________________________
DC/ACUPUNCTURIST____________________
DATE OF LAST VISIT___________________

ANYTHING ELSE I NEED TO KNOW?

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