NAME_____

Medical History

Height_____ Weight_____

Allergies to Medications: Yes / No

*List*_____

Allergies to Environmental: Yes / No

List_____

Allergies to Other: Yes / No

List_____

Cardiovascular:

Heart Disease Yes / No

Elevated Cholesterol Yes / No

High Blood Pressure Yes / No

Stroke Yes / No

Constitutional

Fever Yes / No

Endocrine:

Thyroid disease Yes / No

Diabetes Yes / No

controlled with Oral Medication Yes / No

Insulin Yes / No

diet Yes / No

A1c level_____

Gastrointestinal:

Colitis Yes / No

Diarrhea Yes / No

Genitourinary:

(F) Pregnant Yes / No

STD Yes / No

Ear, Nose, Throat:

Sinusitis Yes / No

Sinus Congestion Yes / No

Cancer: Yes / No

Type_____

Hematologic:

Anemia Yes / No

Bleeds easily Yes / No

Immunologic:

AIDS Yes / No

HIV positive Yes / No

Integumentary:

Rosacea Yes / No

Eczema Yes / No

Musculoskeletal:

Arthritis Yes / No

Rheumatoid Arthritis Yes / No

Neurological:

Brain Tumor Yes / No

Headaches Yes / No

Migraines Yes / No

Seizures Yes / No

Psychiatric:

Alzheimer's Yes / No

Depression Yes / No

Respiratory:

Asthma Yes / No

Chronic Bronchitis Yes / No

Emphysema Yes / No

List all Medications:or bring your list- include eyedrops

_____

_____

_____

_____

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_____

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