MEDICAL HISTORY

Date: _____ Name: _____ Date of Birth: _____

Smoking: ◯ Yes ◯ No ◯ Past

Allergies: _____

Surgical History: _____

Accidents / Injuries / Transfusions

Type	**Date**	**Details**

Hospitalization

Diagnosis Type	**Date**	**Treatment**

Screening Tests (Vision, Hep-A/B/C, Mammogram, Colorectal, Prostate)

Type	**Date**	
		Abnormal Result? Y N
		Abnormal Result? Y N
		Abnormal Result? Y N

Dental History (Mercury fillings, root canal(s), tooth abscess(es)): _____

Recent Lab Work: _____

Personal and Family History Conditions

Please indicate if you or your family have any history with the following conditions:

	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF
ADD/ADHD								
Allergies								
Anemia								
Anxiety								
Arthritis								
Asthma								
Autoimmune Disease								
Blood Transfusion								
Cancer								
Cataracts								
Chemical Sensitivities								
Chronic Fatigue								
Congestive Heart Failure								
Clotting Disorder								
COPD								
Depression								
Diabetes								
Eczema								
Emphysema								
Fibromyalgia								
GERD								
Glaucoma								
Headaches / Migraines								
Heart Disease								
Heart Murmur								
High Cholesterol								
HIV / AIDS								
Hypertension								
Irritable Bowel Syndrome								
Kidney Disease								
Lyme Disease								
Meningitis								
Menopause								
Mental Illness								
Mononucleosis								
Nerve / Muscle Disease								
Obesity								
Osteoporosis								
Ovarian Cysts / PCOS								
Parkinson's / Alzheimer's								
Prostate Disease								
Psoriasis								
Recurrent Strep Infections								
Seizures								
Sickle Cell Anemia								
Stroke								
Substance Abuse								
Thyroid Disease								
Tuberculosis								
Vaginal Infections								
Other								

Reproductive Section

Sexually Active: ◯ Yes ◯ No ◯ Past Sexual Orientation: ◯ Hetero ◯ Gay ◯ Lesbian ◯ Bi ◯ Other

Periods started at age: _____ Typical period length: _____

Date of last menses: _____ Perform monthly breast self-exams? ◯ Yes ◯ No

Menopause (Please indicate age, peri-menopausal & current symptoms & treatment): _____

Last Pap Smear (Please indicate the date and if it was normal, abnormal or any resulting action): _____

Child Births

Year	Vaginal / C-Section	Gender	Complications

Miscarriages / Terminations

Year	Vaginal / C-Section	Gender	Complications

Hormones Used

Current / Past	Reason for Stopping	Side Effects	Dosages

Mammography Results (Please indicate the date and results): _____

Abnormal Vaginal Bleeding (Please indicate the dates, quantity / quality, treatment if applicable): _____