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| **Medical Health History** | | | | | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Aside from a routine exam, are you currently under the care of a physician? ……………………… | | | | | | | | | | | | | | | Yes | | | No |
|  | If yes, what for? | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. In the last 2 years, have you had a serious illness or been hospitalized? …………………............ | | | | | | | | | | | | | | | Yes | | | No |
|  | If yes, what for? | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Please place an “X” into the appropriate box for the listed health issues. Indicate yes if you have had the condition even if you do not currently have that condition. | | | | | | | | | | | | | | | | | | |
| **YES** | | **NO** |  | | | | | | **YES** | **NO** |  | | | | | | | |
|  | |  | Allergies.(Foods, Metals, Medications) Specify: | | | | | |  |  |  | | | | | | | |
|  | |  |  | | | | | |  |  | HIV/AIDS: | | | | | | | |
|  | |  | Alcohol problems: | | | | | |  |  | Immune Deficiency: | | | | | | | |
|  | |  | Drug Dependency- Specify: | | | | | |  |  | Cold Sores : | | | | | | | |
|  | |  |  | | | | | |  |  | Kidney Stones: | | | | | | | |
|  | |  | Asthma | | | | | |  |  | Kidney Disease: | | | | | | | |
|  | |  | Tuberculosis: | | | | | |  |  | Heart Attack: | | | | | | | |
|  | |  | Difficulty breathing: | | | | | |  |  | Heart Disease: | | | | | | | |
|  | |  | Emphysema: | | | | | |  |  | Rheumatic Fever: | | | | | | | |
|  | |  | Chronic Obstructive Pulmonary Disease: | | | | | |  |  | Heart Murmur: | | | | | | | |
|  | |  |  | | | | | |  |  | Heart Surgery: | | | | | | | |
|  | |  | Hepatitis A: | | | | |  |  |  | Artificial Heart Valve: | | | | | | | |
|  | |  | Hepatitis B: | | | | | |  |  | Pacemaker: | | | | | | | |
|  | |  | Hepatitis C: | | | | | |  |  | Angina pectoris: | | | | | | | |
|  | |  | Other Liver Disease: Specify: | | | | | |  |  |  | | | | | | | |
|  | |  |  | | | | | |  |  | High Cholesterol: | | | | | | | |
|  | |  | Arthritis: | | | | | |  |  | High Blood Pressure: | | | | | | | |
|  | |  | Artificial Joint replacement- Specify: | | | | | |  |  | Low Blood Pressure: | | | | | | | |
|  | |  | Dizziness/fainting: | | | | | |  |  | Bleeding Disorder/Haemophilia: | | | | | | | |
|  | |  | Cancer. Specify: | | | | | |  |  | Stroke: | | | | | | | |
|  | |  | Chemotherapy | | | | | |  |  |  | | | | | | | |
|  | |  | Radiation therapy: | | | | | |  |  | Nervousness/Psychiatric condition: | | | | | | | |
|  | |  | Diabetes Type 1: | | | | | |  |  | Organ Transplant : If yes, specify: | | | | | | | |
|  | |  | Diabetes Type 2: | | | | | |  |  | Thyroid Disease. If yes:  **Hyper**  **Hypo** | | | | | | | |
|  | |  | Eating disorder. If yes: anorexia bulimia | | | | | |  |  | Surgeries- specify: | | | | | | | |
|  | |  | Epilepsy or Seizures: | | | | | |  |  |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | |
| 1. Are you taking any medications, prescriptions or herbal remedies? ………….. | | | | | | | | | | | | | | | | Yes | | No |
|  | | If yes, please list: | |  | | | | | | | | | | | | | | |
|  | |  | |  | | | | | | | | | | | | | | |
|  | |  | |  | | | | | | | | | | | | | | |
| 1. Have you recently lost or gained a significant amount of weight? ……………………………….. | | | | | | | | | | | | | | | | Yes | | No |
| If yes, how much? ……………………………………..…………….......... | | | | | | | | | | | | Gained:      kg/lbs | | Lost:      kg/lbs | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Do you smoke or use chewing tobacco? ……………………………………………………………. | | | | | | | | | | | | | | | | Yes | | No |
| If yes, **which** and for how long? | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Do you frequently have indigestion? ………………………………………………………………… | | | | | | | | | | | | | | | | Yes | | No |
|  | | | | | | | | | | | | | | | | | | |
| 1. If yes to question #7, do you take anything for the indigestion? ………………………………… | | | | | | | | | | | | | | | | Yes | | No |
|  | If yes, what do you take? | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. Women: Are you pregnant? ……………………………………………………………………. | | | | | | | | | | | | | | | | Yes | | No |
| 1. Do you have any other health issues which have not been addressed above? ………….………... | | | | | | | | | | | | | | | | Yes | | No |
|  | If yes, please list: | | | |  | | | | | | | | | | | | | |
|  |  | | | |  | | | | | | | | | | | | | |
|  |  | | | |  | | | | | | | | | | | | | |
| **Name: (Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | **Today’s Date:**  **,2018** | | | | | |