|  |  |
| --- | --- |
| **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** |