

MEDICAL HISTORY

Client's Name: _____

Full Name of Physician: _____

Date of Last Physical Exam: ___/___/___

Do you have allergies to any medications? ___ yes ___ no

If yes, which ones: _____

Medications you are currently taking:

Name: _____ Dose: _____

How often do you take it? _____

Name: _____ Dose: _____

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Name: _____ Dose: _____

How often do you take it? _____

Name: _____ Dose: _____

How often do you take it? _____

Do you have, or have ever had:

1. Asthma, allergies, hay fever, or sinusitis? ___ yes ___ no

2. Heart problems or high blood pressure? ___ yes ___ no

3. Diabetes or thyroid problems? ___ yes ___ no

4. Liver, kidney, or lung disease? ___ yes ___ no

5. Ulcers or stomach problems? ___ yes ___ no

6. Hepatitis or jaundice? ___ yes ___ no

7. Epilepsy or strokes? ___ yes ___ no

8. Head injury with loss of consciousness? ___ yes ___ no

9. Bleeding or clotting disorders? ___ yes ___ no

10. Arthritis, painful joints, or skin rash? ___ yes ___ no

11. Cancer, swollen glands, or night sweats? ___ yes ___ no

12. AIDS, or positive HIV test? ___ yes ___ no

13. Any operations? ___ yes ___ no

14. Problems with sexual functioning? ___ yes ___ no

15. Are you on any particular diet? ___ yes ___ no

16. Women: Do you take birth control pills? ___ yes ___ no

Are you pregnant? ___ yes ___ no

Date of first day of last menstrual period: ___/___/___

Client signature

Date

Parent/Guardian Signature

Date

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