Patient Health History and Medication, Page 1 of 2

Check if a blood relative has any of the following conditions and specify the relationship:

	Yes	Relationship (mother, father, sister, etc.)
Alcoholism	________	______________________________
Anxiety / Post Traumatic Stress Disorder	________	______________________________
Depression	________	______________________________
Coronary artery disease	________	______________________________
Diabetes	________	______________________________
Psoriasis	________	______________________________
Inflammatory bowel disease	________	______________________________
Gout	________	______________________________
Kidney Stones	________	______________________________
Cancer	________	______________________________
Thyroid Disease	________	______________________________
Chronic Renal Failure Syndrome	________	______________________________

Check if YOU have or have had any of the following:		*****Approximately how many months or years have you had this?**
Abnormal kidney function	________	__________________________
Kidney stones	________	__________________________
Abnormal liver function	________	__________________________
Bladder Problems	________	__________________________
Blood clots, thrombi or emboli	________	__________________________
Bowel problems	________	__________________________
Cancer - Type____________________	________	__________________________
Congestive heart failure	________	__________________________
Coronary artery disease	________	__________________________
Coronary artery bypass	________	__________________________
Depression	________	__________________________
Diabetes: Type I ______ Type II ______	________	__________________________
Fractures: What was fractured ________________	________	__________________________
Headaches	________	__________________________
Hypertension / High blood pressure	________	__________________________
Hysterectomy or Ovary Removal	________	__________________________
Lung disease / Breathing problems	________	__________________________
Thyroiditis	________	__________________________
Thyroid disease	________	__________________________

If applicable, when was your last menstrual period? __________________________

Have you had any serious illnesses or surgeries NOT listed above? If so, list them below.

____

____

Patient Health History and Medication, Page 2 of 2

List all medications (prescriptions, over the counter, vitamins/supplements) you are currently taking:

Name	Strength	How Many	How Often	How many months or years have you been taking this?

List any allergies and the reaction you have:

Allergen	Reaction	Allergen	Reaction

1. How happy was your childhood? Circle one: 0 (Very Happy) 1 2 3 4 5 6 7 8 9 10 (Miserable)
2. Have you ever been the victim of or exposed to violence? Circle one: Yes or No
3. Have you ever had a substance abuse problem? Circle one: Yes or No
4. Did either of your parents suffer from substance abuse? Circle one: Yes or No
5. Did your parent's divorce before your 18th birthday? Circle one: Yes or No