Confidential Medical History

Your chief complaint or symptom: (Use back side of page if necessary)	**Previous Diagnosis:** (Use back side of page if necessary)

When and how did this condition begin? (Use back side of page if necessary)

Treatment you have received for this condition: (Use back side of page if necessary)

HEALTH HABITS	Yes	No	**Frequency?** (# of times per day/wk/mnth/yr)	**Duration?** (hrs/mins/days/years)
Do you exercise?				
Do you smoke?				
Do you drink alcohol?				
Substance Abuse?				

DIET	**Typical Breakfast**	**Typical Lunch?**	**Typical Dinner?**	**Typical Snacks/Drinks?**

RECENT CONDITIONS OF...

___ Dizziness / lightheadedness
___ Fatigue
___ Headaches (location:)
___ Periods of unconsciousness
___ Swelling or edema (where:)
___ Swollen glands
___ Trauma
___ Other:

STRESS	**Low**	**Med**	**High**
Home			
Work			
Other			

PAST ILLNESS

___ Chicken pox
___ Diphtheria
___ mumps
___ pneumonia
___ Polio
___ Rheumatic fever
___ Rubella
___ Scarlet fever
___ Tetanus
___ Trauma
___ Herpes
___ Venereal disease

PAST DIAGNOSIS

___ AIDS/HIV
___ Anemia
___ Cancer (Type:)
___ Cirrhosis
___ Diabetes
___ Epilepsy
___ Heart attack
___ Heart disease
___ Hemophilia
___ Hepatitis
___ High blood pressure
___ Mononucleosis
___ Stroke
___ Tuberculosis
___ Anxiety disorders
___ Depression
___ Sexual/physical abuse
___ Suicidal thoughts
___ Epilepsy or seizures
___ Osteoporosis

List surgeries or hospitalizations: Use back side of page if necessary)

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List medications: (prescription, non-prescription and supplements. Use back side of page if necessary)