



Medical History Form

Section 1: Personal Information

Name: _____ Date: _____

Email: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Fax: _____ Date of Birth: _____

Section 2: Medical Information

Primary Care Physician: _____

Physician Phone: _____ Last Physical: _____

Height: _____ feet _____ inches Weight: _____ lbs

Smoker: _____ Yes _____ No

Alcohol: _____ Yes _____ No If so, how many times per week: _____

Allergies: _____

Current Prescriptions: _____

Current Supplements (Vitamins, Herbs, Minerals): _____

Family History (Select diagnosed disorders/ diseases of immediate family members):

- | | |
|---|---|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular (heart) Disease | <input type="checkbox"/> Emotional/ Mental Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Cancer What type? _____ | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Lipid (cholesterol) Disease | <input type="checkbox"/> Endocrine Disorder |

Personal History (Select your personal diagnosed disorders/ diseases):

- | | |
|---|---|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular (heart) Disease | <input type="checkbox"/> Emotional/ Mental Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Cancer What type? _____ | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Lipid (cholesterol) Disease | <input type="checkbox"/> Endocrine Disorder |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Genital/ Urinary Disorder |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Muscular/ Skeletal Disorder | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Liver Disease | |

For Women Only

Have you had a hysterectomy? No Full Partial Date: _____

Reason: _____ Date of last Menstrual Cycle: _____

Tubal Ligation: Yes No Are you currently pregnant: Yes No

How many times have you been pregnant: _____ Given birth: _____

Date of last Mammogram: _____ Abnormal: Yes No

If yes, please explain:

Date of Last Pap Smear: _____ Abnormal: Yes No

If yes, please explain:

	Severe	Moderate	Mild	None
Female Only				
Vaginal Dryness				
Male Only				
Erectile Dysfunction				

Night Sweats				
Dry Skin				
Dry Hair				
Hair Loss				
Weight Gain				
Unexplained Weight Loss				
Bladder Infections				
Yeast Infections				
Difficulty Concentrating				
Irritability/ Stress				
Mood Swings				
Breast Tenderness				
Nervousness				
Anxiety				
Migraines				

Insomnia				
Sex Drive Loss				
Fatigue				
Depression				
Muscle Atrophy (Loss)				
Cold/ Heat Intolerance				
Decreased Desire/ Ability to Exercise				
Painful Joints				
Decreased Energy/ Endurance				
Decreased Sense of Well Being				
Water Retention				
Exhaustion in the Morning				
Exhaustion in the Afternoon				

