HEALTH HISTORY INFORMATION

Last Name		First Name	Middle Initial
Sex (Circle One):	Male Female	DOB:	

Medical History : (*Circle all that apply)*

Heart Problems	Y	N	Stroke	Y	N	Arthritis	Y	N	Poor Circulation	Y	N
Allergies	Y	N	Headaches	Y	N	Hypertension	Y	N	Diabetes	Y	N
Palpitations	Y	N	Other:								

Medical History : (*Circle all that apply)*

Insomnia	Y	N	Decreased Sex Drive	Y	N	Depression	Y	N
Fatigue	Y	N	Night Sweats	Y	N	Other:		

List Any Medical Problems That Other Doctors Have Diagnosed

List Current Medical Problems

Hospitalizations/Surgeries?		
Year	**Reason**	**Hospital**

List your Prescribed Drugs, Over the Counter Drugs, Vitamins and Inhalers		
Name of Drug	**Strength**	**Frequency**

Allergies to Medications	
Name of Drug	**Reaction You Had**

Use of Alcohol: Never___ Rarely___ Moderate___ Daily___
Use of Tobacco: Never___ Previously, but quit___ Current packs/day___

Family Medical History:

Family Member	**Age**	**If Deceased, at what age?**	**Major illness or chronic conditions:**
Father			
Mother			
Siblings			

FOR PROVIDER USE ONLY

□Kidney Stones □Caffeine Intolerance □Supplements □Diet

Glucoma □Arrythmias

Previous Procedures

□Photosensitizing Medication □NSAID Use