

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: _____
How often do you take it? _____

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