MEDICAL HISTORY FORM

PAST MEDICAL HISTORY – Circle Yes or No

ADD/ADHD	Yes/No
AIDS/HIV	Yes/No
Abuse/Domestic Violence	Yes/No
Allergies/Hay fever	Yes/No
Anemia	Yes/No
Anxiety Disorder	Yes/No
Arthritis	Yes/No
Autism Spectrum Disorder	Yes/No
Bedwetting	Yes/No
Bladder or Kidney Problems	Yes/No
Blood Disease	Yes/No
Blood Transfusion	Yes/No
Breast Cancer	Yes/No
Breast Problems	Yes/No
COPD	Yes/No
Cancer	Yes/No
Chicken Pox	Yes/No
Chronic Ear Infections	Yes/No
Congestive Heart Failure (CHF)	Yes/No
Constipation	Yes/No
Coronary Artery Disease	Yes/No
Depression	Yes/No
Developmental or Behavioral Disorder	Yes/No
Diabetes	Yes/No
Difficulty Swallowing	Yes/No
Diverticulitis	Yes/No
Ear or Hearing Problems	Yes/No
Eating Disorder	Yes/No
Eczema	Yes/No
Endometriosis	Yes/No
Fibromyalgia	Yes/No
GI Problems	Yes/No
Gout	Yes/No
Headaches	Yes/No

Heart Disease	Yes/No
Heart Problems	Yes/No
Hepatitis	Yes/No
High Cholesterol	Yes/No
Hospitalizations	Yes/No
Hypertension	Yes/No
Hyperthyroidism	Yes/No
Hypothyroidism	Yes/No
Infertility	Yes/No
Kidney Disease	Yes/No
Kidney Stones	Yes/No
Liver Disease	Yes/No
Lung Disease	Yes/No
MRSA Exposure	Yes/No
Meniere's Disease	Yes/No
Mental Disorder	Yes/No
Mental Illness	Yes/No
Muscle Joint or Bone Problems	Yes/No
Obesity	Yes/No
Osteoporosis	Yes/No
Other	Yes/No
Ovarian Cancer	Yes/No
Pre-Eclampsia	Yes/No
Polyps	Yes/No
Pulmonary Embolism	Yes/No
Acid Reflux/GERD	Yes/No
Seizures/Epilepsy	Yes/No
Skin Problems	Yes/No
Stroke	Yes/No
Thrombophilia	Yes/No
Thyroid problems	Yes/No
Tuberculosis	Yes/No
Varicosities	Yes/No
Vision or Eye Problems	Yes/No

Provide any additional information in the space below:

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