Past Medical History

____ ___________________________

Patient Name (Last, First) Date (Month/Day/Year)

General Health Questions (If you answered yes, please list details below)	**Yes**	**No**
Have you experienced any unexplained weight loss?	☐	☐
Have you experienced a recent drop in energy?	☐	☐
Are you currently pregnant and/or nursing?	☐	☐
Are you currently taking oral contraceptives?	☐	☐
Are you currently taking any supplements?	☐	☐
Are you currently taking any prescribed medications?	☐	☐
Are you currently taking any over the counter medications?	☐	☐
Social Health Questions	**Yes**	**No**
Do you exercise? If yes, how many days per week? _____ days, _____min per day	☐	☐
Do you smoke? If yes, how many packs per day? _____ / day	☐	☐
Do you use any recreational drugs? If yes, please list: ___________________________	☐	☐
Health History Questions (If you answered yes, please list details below)	**Yes**	**No**
Have you been in any accidents?	☐	☐
Have you ever had any major traumas or injuries?	☐	☐
Have you ever been hospitalized or had overnight stays in the ER?	☐	☐
Have you ever had any surgeries?	☐	☐
Have you ever had any major illnesses?	☐	☐

Please check all that apply:

Medical Condition	**Yes**	**No**	***Medical Condition***	**Yes**	**No**
Abdominal pain	☐	☐	Fibromyalgia	☐	☐
Allergies/Asthma	☐	☐	Heart disease	☐	☐
Arthritis	☐	☐	Herniated Disc	☐	☐
Auto-Immune Disorder	☐	☐	High blood pressure	☐	☐
Cancer/Tumor	☐	☐	High cholesterol	☐	☐
Chest Pain (Angina)	☐	☐	Multiple sclerosis	☐	☐
Depression/Anxiety	☐	☐	Pacemaker	☐	☐
Diabetes: Type I | Type II	☐	☐	Other: ____________________	☐	☐

Please list all details from any questions you answered yes to above:

____

Please list all major diseases/disorders associated with any family members:

____

Patient Signature: ___________________________________ Date: _____________________

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