

## Medical History Form

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Circle yes or no Have you or any immediate family member ever been told they have:					Circle yes or no		
	Self		Family		Do you have a history of:		
Cancer	Yes	No	Yes	No	Allergies/ asthma?	Yes	No
Diabetes	Yes	No	Yes	No	Headaches?	Yes	No
High Blood Pressure	Yes	No	Yes	No	Sexually transmitted diseases/ AIDS?	Yes	No
Heart problems	Yes	No	Yes	No	Tuberculosis?	Yes	No
Angina/ chest pain	Yes	No	Yes	No	Seizures?	Yes	No
stroke	Yes	No	Yes	No	Bronchitis?	Yes	No
Osteoporosis	Yes	No	Yes	No	Kidney Disease?	Yes	No
arthritis	Yes	No	Yes	No	Rheumatic Fever?	Yes	No
					Ulcers?	Yes	No
In the past 3 months have you had or do you experience:					Are your symptoms (check one): getting worse, the same, improving		
A change in <u>your</u> health?		Yes	No		How are you sleeping at night? (Check one) Fine , moderate difficult , severe difficult , need medication to sleep		
Nausea/ vomiting?		Yes	No				
Fever/ chills/ sweats?		Yes	No				
Sudden weight loss?		Yes	No				
Numbness/ tingling		Yes	No		Please list your medications:		
Changes in appetite?		Yes	No		Have you ever been hospitalized or had surgery? Explain:		
Difficulty swallowing?		Yes	No				
Changes in bowel or bladder function		Yes	No				
Shortness of breath?		Yes	No				
Dizziness?		Yes	No		What is your occupation?		
Upper respiratory infection?		Yes	No				
Urinary tract infection?		Yes	No				
Are you currently:					Please explain your job duties:		
Pregnant?		Yes	No		In what physical activities do you participate and how often?		
Depressed?		Yes	No				
Under stress?		Yes	No				
Do you, or have you in the past smoked tobacco? Yes No							
If yes, _____ packs/ week					What is your goal for coming to therapy?		
Last tobacco use							
Do you drink alcoholic beverages? Yes No If yes, _____ / week?							