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Brief Health Information Form

A. Identification

Name:____ Date: ______________

B. History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List all medications or drugs you take or have taken in the last year-prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

Name ______________________
Date ______________

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. **Medical Providers**

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. **Health habits**

1. What kinds of physical exercise do you get? ______________________

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? ______________

3. Do you try to restrict your eating in any way? How? Why? ______________________

4. Do you have any problems getting enough sleep? ______________________

5. How much alcohol do you drink each day? Is this a matter of concern to you or of any of your family members? Do you use any other substances? ______________________

6. Please identify any food supplements or homeopathic remedies that you use regularly: ______________________

Name ____________________

Date ____________

E. For women only

1. At what age did you start to menstruate (get your period): ________

2. Menstrual period experiences:
   a. How regular are they'? ____________________
   b. How long do they last? ____________________
   c. How much pain do you have? ____________________
   d. How heavy are your periods? ____________________
   e. Other experiences during period? ____________________

3. Please list your pregnancies:

	Your age	Miscarriage	Abortion		Problems?
1.					
2.					
3.					
4.					
5.					
6.					

4. Menopause:
   a. If your menopause has started, at what age did it start? ____________
   b. What signs or symptoms have you had? ____________________

F. Other

Please identify any other medical, physical and/or emotional problems that you are concerned about:

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.