

# Medical History Questionnaire

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Please tick any of the conditions or symptoms you have or had a history of:

**PAIN:**

- Headaches
- Migraines
- Back
- Neck
- Other: \_\_\_\_\_

**THYROID:**

- Hypo
- Hyper
- Removed (date): \_\_\_\_\_

**ALLERGIES:**

- Foods: \_\_\_\_\_
- Drugs: \_\_\_\_\_
- Chemicals: \_\_\_\_\_
- Hay Fever
- Pollen, Dust, Grasses
- Psoriasis
- Eczema
- Asthma

**CANCER:**

- Chemotherapy
- Organ Removed: \_\_\_\_\_  
(date): \_\_\_\_\_
- Natural Therapies
- Type of Cancer: \_\_\_\_\_

**BLOOD SUGAR:**

- Diabetes
- Hypoglycemia

**RESPIRATORY:**

- Lung Disease
- Pneumonia
- Asthma

**BONES/JOINTS:**

- Osteoporosis
- Arthritis
- Gout

**HEART/CIRCULATORY:**

- Irregular Heart
- Heart Murmur
- Chest Pain/Angina
- Heart Disease
- Stroke
- High Blood Pressure
- High Cholesterol
- Dizziness
- Fainting
- Anemia

**GASTROINTESTINAL:**

- Chronic Constipation
- Irritable Bowl Syndrome
- Diverticulitis
- Prolapse
- Chronic Diarrhea
- Hemorrhoids
- Hernia
- Ulcers
- Liver Disease: \_\_\_\_\_
- Gall Bladder: \_\_\_\_\_
- Organ Removed: \_\_\_\_\_  
(date): \_\_\_\_\_

**REPRODUCTIVE FEMALE:**

- Bleeding Problems
- Endometriosis
- Polycystic Ovaries
- PMS
- Organ Removed: \_\_\_\_\_  
(date): \_\_\_\_\_
- Birth Defects

**MALE:**

- Prostate Problems
- Organ Removed: \_\_\_\_\_  
(date): \_\_\_\_\_

# Medical History Questionnaire pt 2

## FAMILY HISTORY

Have any of your family members suffered any of the previous illnesses? In particular, cancer, diabetes or osteoporosis?

	AGE	STATE OF HEALTH	CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHERS	_____	_____	_____
	_____	_____	_____
SISTERS	_____	_____	_____
	_____	_____	_____

## OTHER HISTORY:

### SMOKING

Do you smoke? \_\_\_\_\_

Cigarettes per day? \_\_\_\_\_

If you used to smoke, when did you quit?  
(date) \_\_\_\_\_

### COFFEE

Cups of coffee per day? \_\_\_\_\_

Cups of tea per day? \_\_\_\_\_

### ALCOHOL

Daily? \_\_\_\_\_

Weekends? \_\_\_\_\_

Rarely? \_\_\_\_\_

Socially? \_\_\_\_\_

## ARE YOU TAKING ANY OTHER MEDICATIONS?

Blood Pressure

Cholesterol

Cardiac Medication

Diuretics

Anticoagulants

Beta Blockers

Tranquilizers

Hormones/HRT

Birth Control Pills

Aspirin

Vitamins/Herbs

Laxatives

Over the counter prescriptions

Steroids (eg. Prednisone, Cortisol, Cortisone)

Arthritic

Anti-inflammatories