

Medical History Form

Name: _____ First name: _____ DOB: ___/___/_____

1- Present health concerns/symptoms/issues: _____

2- List medical test and treatments relating to the above: _____

3- Past health complications or surgeries _____

4- Current prescribed medication with relating condition _____

Smoking (including passive smoking) _____

Past & current alcohol (type and frequency) _____

Past or current recreational drugs (type & frequency) _____

Known allergies _____

Vitamins & Supplements _____

Last vaccination _____

(If not enough space, please use other side of page)

Current Symptoms Review (Please tick & circle where applicable)

Digestion

- poor appetite
- abdominal pain / leaky guts syndrome
- indigestion / stomach acidity / reflux / heart burn
- trouble swallowing
- diarrhoea / constipation / bloating
- nausea or vomiting
- rectal bleeding or blood in stools
- Irritable bowel syndrome / change in bowel habits

Cardiovascular

- chest pain
- history of angina or heart attack
- high/low blood pressure
- irregular beat / heart murmur
- poor blood circulation / heavy legs / varicose veins
- easy bruising or other: _____

Pulmonary/lungs

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

Muscle/joint/bone/spine

- swelling of ankles or legs
- Pain, weakness or numbness/tingling in:
 - arms or hands
 - lower back or hips
 - legs or feet
 - neck or shoulders
 - sciatica / torticoli or spontaneous cramps
 - poor repair of damage tissues
 - low bones density / easy breakage

Neurological

- stroke / seizure / epilepsy
- fibromyalgia / motor neuron disease
- blackouts or loss of consciousness
- restless legs syndrome
- general anaesthetic / near drowning
- Parkinson's/Alzheimer's or other: _____

Hormone

- diabetes
- thyroid disease
- excessive thirst

General

- weight gain/loss during last 6 months
- poor sleep / insomnia
- headache/migraines
- depression / anxiety / stress / work overload / fear
- loss of taste/smell or nose bleed
- dizziness / vertigo / clumsy
- abnormal sweating / body temperature
- cholesterol
- poor libido/sexual disfunction _____
- low energy / tiredness / chronic fatigue
- Addictions: _____
- poor immune system _____

Eyes, ears, nose, throat

- blurred vision or other change in vision
- eyes sore/itchy/dry _____
- glaucoma or cataracts
- loss of hearing or ringing in ears
- tonsillitis / sinus problems/other: _____

Skin

- Eczema / rash / hives
- dermatitis / psoriasis / acne
- dry skin or other: _____

Women only

- irregular period or painful
- bleeding between periods
- endometriosis / hysterectomy
- abnormal breast or vaginal discharge
- fertility & conception problems
- other _____

Men only

- PSA

Learning & behaviour difficulties

- speech difficulties
- spelling / times tables
- concentration / confidence / self esteem
- reading / writing / dyslexia
- frustration / anger / aggression
- co-ordination
- thoughts / short term memory difficulties
- autism/ADD/ADHD
- other: _____

Other specific unlisted symptoms: _____

How do you rate yourself? (1 being worst to 10 being best):

General well being: _____ Physical: _____ Mental: _____

Date: ___/___/_____