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Medical History

For the following questions, please list as much information as you know. Leave blank the questions that you are unable to complete.

• Client Name: _____ DOB: _____

• Primary Care Physician: _____ Phone: _____

Address: _____ City, State, Zip: _____

• When was the last time you had a physical (approximate date): _____

• What were the results:

• Present Medical Conditions (eg. High blood pressure, high cholesterol, diabetes):

• Past Medical Conditions (eg. Surgeries, chronic ailments):

• Are you in any physical pain right now? If so, please describe:

• Have you ever had a head injury (either losing or not losing consciousness)?

If so, please describe:

• Any history or seizures?

• Any supplements, vitamins or other non-prescription products that you are currently taking (include essential oils)?

Prescribed Medication (current and history). List as much information as you know:

Current Medications:

Medication	Dosage/Frequency	Prescribed by	Reason	Date last used	Side effects

Historical medication (medicines you've taken in the past):

Medication	Dosage/Frequency	Prescribed by	Reason	Date last used	Side effects