CONFIDENTIAL MEDICAL HISTORY

Name____Date of Birth_____________

Please Print

	YES	NO
1. Are you having pain or discomfort at this time?..		
2. Have you been a patient in the hospital during the past two years?...		
3. Have you been vaccinated? List any reactions you had:..		
4. Have you taken any medicine or drugs during the past two years?...		
5. Are you allergic to or made sick by any drugs or medications? Specify………………….…………..		
6. Which of the following do you have now or have had in the past (check YES or NO):		

	YES	NO		YES	NO		YES	NO
Heart Failure			Emphysema			Pain in Jaw		
Heart Disease or Attack			Chronic Cough			Immunodeficiency		
Angina Pectoris			Tuberculosis (TB)			Hepatitis A		
High Blood Pressure			Asthma			Hepatitis B		
Heart Murmur			Hay Fever			Liver Disease		
Rheumatic Fever			Sinus Trouble			Yellow Jaundice		
Congenital Heart Lesions			Allergies or Hives			Blood Transfusion		
Scarlet Fever			Diabetes			Hemophilia		
Artificial Heart Valve			Thyroid Disease			Cold Sores		
Heart Pacemaker			X-ray or Cobalt Treatment			Epilepsy or Seizures		
Heart Surgery			Chemotherapy			Fainting/Dizziness		
Artificial Joint			Arthritis			Nervousness		
Anemia			Rheumatism			Sickle Cell Disease		
Stroke			Cortisone Medication			Bruise Easily		
Kidney Trouble			Glaucoma			Excessive Bleeding		
Ulcers			Mitral Valve Prolapse					

	YES	NO
7. Do you feel very nervous about having dental treatment?..		
8. When you walk upstairs or take a walk do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?..		
9. Do your ankles swell during the day?..		
10.Have you lost or gained more than 10 pounds in the past year?...		
11.Do you ever wake up from sleep short of breath?..		
12.Are you on a special diet?..		
13.Has your medical doctor ever said you have a cancer or tumor?..		
14.Do you have any disease, condition or problem not listed? Specify……………………………........ ……………………………………………………………………………………………………….		
15.WOMEN: Are you pregnant now?...		
Are you taking birth control pills?...		
16.List the medications you are currently taking:……………………………………………………… ……………………………………………………………………………………………………….		
17. List any significant illnesses in your family history………………………………………………... …...……………………………………………………………………………………………………		

18.Physician’s Name____Phone____________________

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medications change, I will inform my homeopath.

Date_____________ Signature of Client, Parent or Guardian____