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 adverse responses…….....	___	___
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	___	___	Hepatitis A	___	___
Angina Pectoris	___	___	Tuberculosis (TB)	___	___	Hepatitis B	___	___
High Blood Pressure	___	___	Asthma	___	___	Liver Disease	___	___
Heart Murmur	___	___	Hay Fever	___	___	Yellow Jaundice	___	___
Rheumatic Fever	___	___	Sinus Trouble	___	___	Blood Transfusion	___	___
Congenital Heart Lesions	___	___	Allergies or Hives	___	___	Hemophilia	___	___
Scarlet Fever	___	___	Diabetes	___	___	Cold Sores	___	___
Artificial Heart Valve	___	___	Thyroid Disease	___	___	Epilepsy or Seizures	___	___
Heart Pacemaker	___	___	X-ray or Radiation	___	___	Fainting/Dizziness	___	___
Heart Surgery	___	___	Chemotherapy	___	___	Nervousness	___	___
Artificial Joint/apparatus	___	___	Arthritis	___	___	Sickle Cell Disease	___	___
Anemia	___	___	Rheumatism	___	___	Bruise Easily	___	___
Stroke	___	___	Cortisone Treatment	___	___	Excessive Bleeding	___	___
Kidney Trouble	___	___	Glaucoma	___	___			
Ulcers	___	___	Mitral Valve Prolapse	___	___	Sex Trans Dis. STD	___	___

	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? For how long?.....	___	___
16. List the medications you are currently taking:…… ……		
17. 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_____