breathtaking
Holistic Counseling Services

MEDICAL HISTORY FORM

All information is confidential. Please Print.

Name:_____ _____ _____
Last First M.I.

Client ID #_____ D.O.B.:_____

Primary Doctor:_____Telephone:_____

Date of last physical exam:_____Results:_____
If it has been more than one year, a new physical is recommended

If you are presently receiving medical care please explain:_____

_____. For how long?_____

Height:_____ Weight:_____

Present History: (Check all that apply)
I currently have the following physical complaints:

_____ Fever	_____ Infections or abscesses	_____ Loss of hearing/buzzing or ringing
_____ Bleeding Gums	_____ Double vision/loss of vision	_____ Migraine or recurrent headaches
_____ Dizziness	_____ Severe nose bleeds	_____ Blood in urine/kidney stones
_____ Convulsions	_____ nausea or vomiting	_____ Spitting up phlegm/mucus/blood
_____ Stomach Pain	_____ Coughing/breathing difficulties	_____ Frequent colds or sore throat
_____ Blueness of lips/nails	_____ High Blood pressure	_____ Numbness or tingling
_____ Night Sweating	_____ Pain/difficulty urinating	_____ Chronic pain in muscles, bones or extremities

_____I do not have any of the above.

Medical Conditions/Past History: (Check all that apply)

_____ Cancer	_____ Strokes	_____ Thyroid problems
_____ Alzheimer's	_____ Heart Murmur	_____ Pneumonia
_____ Cirrhosis	_____ Blood infection	_____ Allergies/Hay Fever
_____ Heart attack/heart disease	_____ Diseases of the arteries	_____ Asthma
_____ Lupus	_____ Tendency to bleed easily	_____ Abnormal chest X-ray
_____ Lyme Disease	_____ Anemia	_____ Whooping cough
_____ Parkinson's Disease	_____ Ulcers	_____ jaundice
_____ Multiple Sclerosis	_____ Prostrate problems	_____ Gall Bladder Problems
_____ Cystic Fibrosis	_____ Head injuries	_____ Scarlet Fever/Rheumatic Fever
_____ Cerebral Palsy	_____ Dizziness or fainting spells	_____ Mumps
_____ Muscular Dystrophy	_____ Eczema/psoriasis	_____ Measles
_____ Polio	_____ Mononucleosis	_____ German measles
_____ Seizure Disorders	_____ Malaria	Chicken Pox

_____ Urinary tract infections or kidney stone

_____ Broken bones/significant injuries:

_____ Surgery/type & when?

_____ Hepatitis/type & when treated? Diet Controlled? Yes _____ No _____

_____ Diabetes/insulin type & dosage? _____ Last chest x-ray:_____

_____ Sexually Transmitted Disease (STD)/type & when treated?_____

_____ Risk factor for AIDS?_____

_____ I have never had any of the above

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Client Name:_____ D.O.B._____

Allergies: (Circle/Explain)

Do you have any food allergies? YES NO If yes, please explain:_____

Do you have any allergies/adverse reactions to drugs? YES NO If yes, please explain:_____

Women Only:

Do you have any menstrual problems? YES NO If yes, please explain:_____

Date of last GYN exam: _____

Are you now pregnant? Yes No If "yes", are you receiving prenatal care? Yes No

If you have had any of the following please indicate the number:

_____Pregnancies _____Miscarriages _____Stillbirths ____Abortions

Childhood History

Did your mother experience any complications during her pregnancy with you? (Ex: R.H. neg., toxemia, diabetes, substance abuse)

Yes No If yes, specify: _____

Were there any complications during your birth? Yes No If yes, specify:_____

Early Development: Did you have any difficulties in the following areas?

Walking Yes No If yes, explain:_____

Talking Yes No If yes, explain:_____

Toilet Training Yes No If yes, explain:_____

Any unusual childhood illnesses? Yes No If yes, explain:_____

Any child care difficulties? Yes No If yes, explain:_____

Anysocial/behavioral problems? Yes No If yes, explain:_____

Family Medical History:

Father: Current Age:_____Statement of current health:_____If deceased, list the age at death and cause of death:
_____

Mother: Current Age:_____Statement of current health:_____If deceased, list the age at death and cause of death:
_____

Siblings: Number of brothers:_____ Number of sisters:_____

Health problems:_____

Husband/Wife: Health Problems:_____

Children: Health Problems:_____

Family Diseases: (Please check if your relatives have had any of the following. Include grandparents, aunts, and uncles, but exclude cousins, relatives by marriage, and half-relatives)

_____ Heart Attacks/disease	_____ Congenital Heart Disease	_____ Sickle Cell Trait/Disease
_____ Strokes	_____ Epilepsy	_____ Leukemia or cancer
_____ High Blood Pressure	_____ Elevated Cholesterol	_____ Diabetes
_____ TB	_____ Alzheimer's	_____ Cystic Fibrosis

_____ Other:_____