Medical History

Name ______________________ **Date:** ____________

Who is your primary care provider? Include phone number: ____________________

What medications are you taking now?

	Name	Dosage	Name	Dosage	Name	Dosage	Name	Dosage
Prescription:								

Over the counter (include vitamins, minerals, herbs and other *natural* remedies): ____________

Do you have any allergies? If so, to what? Foods, dusts, pollens, animals, etc. ____________

Medications? ____________________

Indicate whether you have had any of the following illnesses.

	NOW		Ever	
	Yes	No	Yes	No
AIDS infection	G	G	G	G
Arthritis	G	G	G	G
Blood diseases/ anemia	G	G	G	G
Cancer	G	G	G	G
Constipation	G	G	G	G
Dizziness	G	G	G	G
Ear aches or infections	G	G	G	G
Fainting	G	G	G	G
Fatigue, excessive	G	G	G	G
Headaches	G	G	G	G
Paralysis	G	G	G	G
Head injury	G	G	G	G

	NOW		Ever	
	Yes	No	Yes	No
Heart disease	G	G	G	G
Hepatitis	G	G	G	G
High blood pressure	G	G	G	G
Other immune problems	G	G	G	G
Numbness and/or tingling	G	G	G	G
Prostate problems	G	G	G	G
Seizures	G	G	G	G
Sexually transmitted diseases	G	G	G	G
Sleep problems	G	G	G	G
Ulcers of the GI tract	G	G	G	G
Urine infections	G	G	G	G
Vision or hearing problems	G	G	G	G
Weight gain or loss	G	G	G	G

What is your weight now? ____________

Women: Is there any chance you could be pregnant? ____________

Are you using birth control? What kind? ____________

Are your periods regular? Describe. ____________

Do you notice mood changes during your monthly cycle? Describe.

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Do you experience sexual problems with dryness, lack of desire, or lack of response? Describe.

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Men: Do you have prostate problems? Describe. ____________

Do you use condoms? Describe. ____________

Do you experience sexual problems with lack of desire, erection, ejaculation? Describe. ____________

Have you had any surgeries? What kind? When? ____________

What medications have you taken in the past? ____________