GENERAL MEDICAL HISTORY

Total Approach Wellness and Aesthetics
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➢ *Demographics:*

Date Completed _____ / _____ / _____

First Name: _____ Middle Initial: ____ Last Name: _____

➢ *Chief Goal:*

Briefly explain why it is you came to this practice:

➢ *Past Medical History:*

Please check any medical conditions or health problems that you currently have or have had in the past.

Condition	*Now*		*Past*		*Condition*	*Now*		*Past*	
Ankle swelling	❍		❍		Hepatitis/Liver disease	❍		❍	
Anxiety or excess. stress	❍		❍		Herniated Disc	❍		❍	
Artificial joint/implants	❍		❍		High Blood Pressure	❍		❍	
Asthma	❍		❍		High Triglycerides	❍		❍	
Bleeding disorder	❍		❍		Irregular Heart Beat	❍		❍	
Blood Clotting problems	❍		❍		Kidney disease / Stones	❍		❍	
Cancer	❍		❍		Fibrocystic Breasts	❍		❍	
Carpal Tunnel Synd.	❍		❍		Lung or breathing problems	❍		❍	
Chest Pain	❍		❍		Osteoarthritis	❍		❍	
Chronic bronchitis	❍		❍		Osteoporosis/Osteopenia	❍		❍	
Chronic Indigestion	❍		❍		Psoriasis or eczema	❍		❍	
Constipation/diarrhea	❍		❍		Psych. or Emotional Illness	❍		❍	
Depression	❍		❍		Rectal Bleeding	❍		❍	
Diabetes	❍		❍		Rheumatoid Arthritis	❍		❍	
Fibroid uterus	❍		❍		Seasonal allergies	❍		❍	
Fibromyalgia	❍		❍		Seizures Disorder	❍		❍	
Gallbladder disease	❍		❍		Skin problems/dermatitis	❍		❍	
Glaucoma	❍		❍		Stomach Ulcers	❍		❍	
Headaches	❍		❍		Stroke/vascular disease	❍		❍	
Heart Disease	❍		❍		Thyroid disease	❍		❍	
Heel Pain	❍		❍		Tuberculosis	❍		❍	

➢ ***Past Medical History (cont):***

Any significant birth-related events?

Any significant/traumatic injuries?

➢ ***Family History*:**

Do you have a family member (mother, father, grandparents or sibling) with any of the following?
Abbreviations: MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather. If positive, indicate the age in the box at which onset occurred.

						Grandparents			
	Condition	**Mother**	**Father**	**Sister**	**Brother**	**MGM**	**MGF**	**PGM**	**PGF**
☐	Breast Cancer								
☐	Prostate Cancer								
☐	Uterine Cancer								
☐	Ovarian Cancer								
☐	Colon Cancer								
☐	Fibrocystic breast								
☐	Heart Disease/stroke								
☐	High Cholesterol								
☐	Diabetes								
☐	High Blood Pressure								
☐	Osteoporosis/ Osteopenia								
☐	Alzheimer's disease								
☐	Psychiatric illness								

➢ ***Social History:***

Do you use tobacco? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
If yes, what is your occupation? _____
Is the job stressful? ☐ Yes ☐ No
Is your job physically demanding? ☐ Yes ☐ No

Education:
☐ High school/GED ☐ College ☐ Post-Graduate

Martial Status:
☐ Single ☐ Divorced ☐ Married/Partnered

Do you have any children? ☐ Yes ☐ No
If so, kindly provide their gender and their ages: _____

Do they live with you? ☐ Yes ☐ No

➢ ***Surgical History:***

Please list all surgeries that you have had since birth. Include the year.

Surgery	**Year**

➢ ***Previous Studies/Tests:***

Have you had any of the following tests performed?

Yes	No	Test	If yes, what was the month/yr?	Result	
				Normal	Abnormal
☐	☐	Mammography			
☐	☐	PAP Smear			
☐	☐	Uterine Ultrasound			
☐	☐	Bone Density			
☐	☐	Colonoscopy			
☐	☐	Cardiac Testing Type:			

➢ ***Dietary and Exercise History:***

Do you do exercises?	☐ Yes	☐ No
Do you do weight resistant exercises? (Lift weights)	☐ Yes	☐ No
Do you do aerobic exercises?	☐ Yes	☐ No
Do you practice yoga?	☐ Yes	☐ No

I eat at fast-food restaurants _____ times per week.

I consume:

- ☐ Coffee ____ cups per day
- ☐ Regular soft drinks _____ cans/btls per day
- ☐ Diet soda _____ cans/btls per day
- ☐ Energy drinks _____ cans/btls per day
- ☐ Alcoholic beverages _____ per day
- ☐ Water _____ oz. per day

Servings of the following per day:

Meat	_____
Vegetables	_____
Fruit	_____
Nuts	_____
Dairy/Cheese	_____
Bread	_____
Candy/sweets	_____

Do you snack between meals?

What are your favorite snack foods?

➢ ***Prescription Medications – Prescribed by a Physician:***

This includes any medication or therapy prescribed by a physician.

	Medication	**Strength: units in mgs, gms, IU, mcg**	**At what times do you take this medication?**	**Year Started.**	**Are you currently taking this medication?**
1					
2					
3					
4					
5					
6					
7					
8					

Vitamins and Over-the-Counter (OTC) Products:

This includes any pill, substance, or supplement that you bought at a store or pharmacy without a doctor's prescription.

	Supplement	Manufacturer	Major Ingredients	Strength of Ingredients	For what reason do you take this supplement
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

➢ ***Allergies:***

☐ No known allergies to medications

Antibiotics	☐ Penicillin	☐ Sulfa	☐ Other antibiotics:
Prescription Medication:	☐ Morphine	☐ Codeine	☐ Aspirin
Environmental Allergies:	☐ Seasonal	☐ Pets	☐ Ragweed, pollen, grasses
Food Allergies:	☐ _____	☐ _____	☐ _____ ☐ _____
Chemical Sensitivities:	☐ Dyes	☐ _____	☐ _____

Any other allergy not noted above?: (please list):

Please describe the reaction to the allergen listed above. Was it life-threatening?

Describe the extent to which you are exposed to chemicals or metals.

Any Mercury Fillings? ☐ Yes ☐ No

➢ ***Physician Information:***

☐ **No Primary Care Physician** ☐ **No Specialist**

Primary Care Physician
Name: _____

Specialist Physician
Name: _____