Integrative Family Health Clinic

Personal Past & Present Medical Problems

Check all Iteams appropriately	Not Ever	Yes Past	Yes Presenet	Date of past
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia				
Arthritis				
Blindness in Either Eye				
Broken Bone(s)				
Cateracts				
Chronic Bronchitis				
Chronic Lung Disease				
Cirrosis of the Liver				
Colon / Bowel Trouble				
Deafness				
Dysentery				
Diabetes				
Ear Infection				
Emphysema				
Enlarged Heart				
Glaucoma				
Gall Stones				
Gout				
Genorrhea				
Hey Feaver				
Heart Murmur as an adult				
Heart Attack				
High Blood Presure				
Hepatitis				
Hemorrhoids				
Kidney Stones				
Nervious Breakdown				
Poor Blood Clotting				
Poilo				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach or Duodenal Ulcer				
Syphilis				

Check all Iteams appropriately	Not Ever	Yes Past	Yes Presenet	Date of past
Skin Disease				
Serious Depression				
Serious Emotional Problems				
Tuberculosis				
Thyroid- Overactive				
Thyroid- Underactive				
Varicose Veins				
Men				
Prostate Problems				
Women				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease				
Other Gynological Problems				
Still Menstrating				
Age Period Started				
Age Period Stopped				
Why Period Stopped				
Number of Pregnancies				
Number of Childern				
Number of Miscarriages				

Hospitalizations, Reason, & Date:

Do you wear artifical devices?	No	Yes, Please list

Do you have allergies?	No	Yes, Please list