CONFIDENTIAL MEDICAL HISTORY FORM

Full name:_____

Please check the appropriate boxes:

Cancer:
Have you ever been diagnosed with any form of cancer?_____
Type?_____
When?_____
Status?_____

Lifestyle:
- Premature ageing
- Chronic Illness
- Excessive physical and mental exertion
  - Conflicts
  - Inappropriate or inadequate physical activity
  - Convalescence

- Family Stress
  - Large Family
  - Increased financial responsibilities
  - Marriage Conflicts
  - Conflicts with children or with parents
  - Loss of loved ones

- Stress at work
  - Poor Motivation
  - Work too routine
  - Interpersonal Rivalry
  - Frustration

- Increased Stress during important changes or phases of life
  - Loss of Job
  - Financial Loss
  - Retirement
  - Menopause
  - Social Isolation

- Stresses of everyday life
  - Large city pressure
  - Social and cultural pressures

- Nutritional Stress
  - Poor dietary habits
  - Intolerance to food, additives or preservatives. What?_____
  - Increased consumption of high caloric value foods
  - Gastrointestinal disorders such as constipation due to a poor diet

- Harmful habits
  - Excessive smoking
  - Excessive alcohol consumption
  - Recreational drugs use

Cardiovascular Problems:
- myocardial infarction
when? _____
- angina pectoris
- tachycardia
- by-pass surgery
when?_____
- hypertension (High blood pressure)
- hypotension (Low blood pressure)

Circulatory:
- poor arterial circulation
- poor venous circulation
- leg cramps
- tired legs
- swollen ankles
- varicose veins
- tingling sensation in arms and leg
- falling asleep of the hands and legs
- leg ulcers

Gastrointestinal Problems:
- irritable bowel syndrome
- acid indigestion
- bloating
- stomach or duodenal ulcer
when?_____
- loss of appetite
- rapid weight gain
- rapid weight loss
- overweight problem
- recurring constipation
- pancreatitis
- pancreatic insufficiency
- hepatitis
- gall bladder problems
- gall stones
- jaundice
- recurring diarrhoea

Pulmonary System:
- tuberculosis
- asthma
- chronic bronchitis
- chronic cough
- emphysema

Upper Respiratory Test
- chronic sinusitis
- allergic sinus problem
- chronic allergic rhinitis
- sinus headaches
- chronic nose bleeds
- chronic colds

Initial please:

CONFIDENTIAL MEDICAL HISTORY FORM CONTINUED

Full name:_____

Neurological Problems:
- nervous disturbances (please name)
- _____
- depressions
- loss of memory
- decreased concentration
- decreased sexual potency
- headaches
- sleep disturbances
- dizziness
- chronic migraine
- reduced vitality
- psychiatric disturbances

Endocrine System:
- diabetes mellitus
- thyroid dysfunction - overactive
  - underactive
- adrenal gland dysfunction
- female menopause (hot flashes, etc.)
- male menopause (andropause-decreased potency)
- other, please list _____

Rheumatic Screen:
- soft tissue rheumatism
- articular rheumatism
- joint pain
- back pain
- rheumatoid arthritis
- other, please list _____

Allergy History:
- Have you ever had an allergic reaction to any of the following;
- food (eggs, milk etc.)
- herbs, plants _____
- medications _____
- hay fever?
- allergic asthma?

- **Infectious or ST diseases**:

_____When?_____

Surgical operations:
What? _____When?_____

Accidents: _____When?_____

General Information:
- Previous medications
  - _____
  - _____
  - _____
  - _____
  - _____
- Medications now on
  - _____
  - _____
  - _____
  - _____
  - _____
- Anticoagulated ?

Since when? _____
Why? _____

When was your last vaccination?
- _____

When were you last ill ?
- _____

Diagnosis?_____

- Do you smoke?
- cigarettes - cigars - pipes
- How many?_____

- Alcohol Consumption?
- wine - beer - spirits
- How much? _____

Nutritional supplements you take and dosage schedule
- _____
- _____
- _____
- _____
- _____

- **Dental amalgam or metal crowns**

- **Pets in the household**

_____ _When?_____

Signature: _____

Date: _____

Print name: _____