

# MEDICAL HISTORY / ANAMNESIS

<b>Patient:</b>	<b>DoB:</b>	<b>Date:</b>
<b>Height:</b>	<b>Weight:</b>	
<b>Personal Medical History (including dates):</b>		
Birth: Childhood: Surgery (age): Inpatient episodes: Diagnosed medical conditions:		
<b>Family Medical History (including dates):</b>		
Mother (age): Father (age): Grandparents:		
		Children (age/sex): Brothers & Sisters:
Others:		
<b>Current State of Health (including dates):</b>		
Complaints (list by importance / provide dates):		
Digestion: Bloating: Heartburn: Nausea:	Belly pain, cramps: Bowel movements: Stool consistency: Undigested foods in stool:	
Sleep: Memory: Concentration: Stress:	Motivation: Mood: Anxiety: Depression:	
Skin: Hair: Nails: Mouth ulcers: Teeth (amalgams / root canals):	Eczema: Acne: Herpes: Psoriasis: Gums:	
Frequent infections: Eye condition: Joints: Weight gain:	Spine disorders: Blood circulation: Periods / PMS: Weight loss:	
Allergies / Hay fever:	Allergies to foods:	
Current medications:		
Current supplements:		
Contraception: Drug intolerances:	Environmental toxic exposure(s): Cosmetics (chemicals): Blood donations:	