WELLNESS BY SANDRA

MEDICAL HISTORY FORM

Today's date: _____

Client name: _____ Age: _____
Address: _____ D.O.B: _____
Phone: _____ Email: _____
Marital Status: (S / M / D / W) Occupation: _____

Referred by: _____

Females:

Regular menstrual cycle?	_____YES	_____NO	_____Days
Normal mammogram?	_____YES	_____NO	_____N/A
Birth Control Use?	_____YES	_____NO	_____Specify
Cysts?	_____YES	_____NO	_____Specify
Miscarriages?	_____YES	_____NO	_____When?
C-sections?	_____YES	_____NO	_____When?

Males:

Prostrate issues?	_____YES	_____NO	_____Specify
Low Testosterone?	_____YES	_____NO	

General (please circle all that apply):

Diabetes	Heart Disease
Osteoporosis	High/Low Blood Pressure
High/Low Cholesterol	Arthritis _____ Where?
Kidney Disease	Genetic Disorders
Mental Illness	Cancer _____Where?
Hypertension	Seizures
Alcohol Use	Drug Use
Tobacco Use	Blood Clots
Anemia	Trouble Breathing
Digestive Issues	Chronic Pain _____Where?
Migraines	Eating Disorder _____Specify

Vitamin Supplements _____
Medications _____
Food Allergies _____