



MEDICAL HISTORY FORM

Date: _____ Name: _____

Past History

Past major illnesses: _____

Past hospitalizations: _____

Adverse reactions to medications, vaccines, etc.: _____

Medications

Current: _____

Past: _____

Vitamins and other natural therapies: _____

Family History

Please list the state of health of the members of your family plus record their present ages. If they are deceased, please state the cause of death and the age at which they died.

Father: _____

Father's mother: _____

Father's father: _____

Mother: _____

Mother's mother: _____

Mother's father: _____

Brothers and sisters: _____

Your children: _____
