Hearth Consultants LLC
Medical History Form

Name________________________ Date of Birth______________ Today's date_____

Please list all medications that you are currently taking and what they are for:

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Have you had any surgeries? Yes / No   If yes, please list them

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Do you have any allergies? Yes/ No If yes, what are you allergic to?

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Do you have diabetes? yes / no		Do you have high blood pressure? yes/ no
Do you have high cholesterol? yes/ no		Have you had a heart attack? yes/ no
Have you had a stroke ? yes/ no		Do you have migraines? yes/ no
Do you have a seizure disorder? yes/ no		Do you have sinus problems? yes/no
Have you had hepatitis? yes/ no If yes, what kind?		Do you have a vision problem? yes/no If yes, please explain:
Do you have a thyroid condition? yes/ no If yes, overactive or under active		Do you have a hearing problem? yes/no If yes, please explain:
Do you have respiratory (lung) problem? y/n If yes, please explain:?		Do you smoke cigarettes/other tobacco products? yes /no If yes, how many per day?
Do you have heart problems? yes/ no If yes, please explain:		Do you drink alcohol/beer? yes/no If yes, how much and how often?
Do you have stomach/bowel problems? yes/no If yes,please explain:		Do you use recreational drugs? yes/no If yes, what and how much
Do you have any bladder/kidney problems? yes/ no If yes,please explain:		Have you been tested for HIV? yes/no If yes,please explain
Do you have any neurological problems? y/n If yes, what kind?		Date of last TB test : Date_____ Was the result positive or negative y/n
Have you had cancer? yes/ no If yes, what kind? If yes, are you under treatment? yes/no If yes, please explain:		Are you on a special diet? yes/ no If yes, what kind of diet?

Does anyone in your family have a mental illness or medical illness? yes/no If yes,please explain:		When was your last physical exam? Date_____ When did you have your last tetanus shot? Date_______
What are your exercise habits like?		What are your sleep habits like?

Client’s Signature ____