Anamnesis Form

NAME: _____ DATE OF BIRTH: _____
OCCUPATION: _____ REFERRAL THROUGH: _____

DATE OF LAST PHYSICAL EXAM: _____
DATE OF LAST CHEST X - RAY: _____
DATE OF LAST EKG: _____
DATE OF LAST LAB WORK (BLOOD, URINE): _____
LIST ANY ABNORMAL RESULTS: _____

SYMPTOMS YOU PRESENTLY HAVE:

1._____
2._____
3._____
4._____

LIST OF PHYSICANS YOU ARE PRESENTLY SEEING:

NAME	SPECIALTY	LOCATION
1: _____		
2. _____		

MEDICINES/DRUGS: List all chemical substances you are taking, even if they are nonprescription (over the counter).

NAME	DOSE	REGULARITY	HOW LONG HAVE YOU BEEN TAKING IT
1. _____			
2. _____			
3. _____			
4. _____			

SUPPLEMENTS: Any vitamins, minerals or similar health products

NAME	DOSE	REGULARITY	HOW LONG HAVE YOU BEEN TAKING IT

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY MEDICAL HISTORY

	if living		**if passed away**	
	Age	Health	Age at death	Cause

Father _____
Mother _____

Brother or Sister

1. _____
2. _____
3. _____
4. _____

Husband or Wife

_____

Children

1. _____
2. _____
3. _____

Has any blood relative ever had	**(please circle)**	**Who?**
Cancer	No Yes	_____
Tuberculosis	No Yes	_____
Diabetes	No Yes	_____
Heart trouble	No Yes	_____
High blood pressure	No Yes	_____
Stroke	No Yes	_____
Epilepsy	No Yes	_____
Mental illness	No Yes	_____
Suicide	No Yes	_____

ALLERGIES: Are you allergic to

1. Any medicine or drug? No Yes

if yes, to which ones:_____

2. Any kind of food? No Yes

if yes, to what kind

_____

3. Anything carried in the air? No Yes

if yes, to what

_____

4. Any other allergies, please list:

_____