NUTRIPHARM
CREATING BALANCE

MEDICAL HISTORY FORM

FULL NAME D.O.B WEIGHT HEIGHT

ADDRESS

OCCUPATION

GP NAME & ADDRESS

EMAIL

PHONE (Day)

PHONE (Eve.)

REFERRED BY

MAIN COMPLAINT INFORMATION:

What are the main reasons for the consulation?

Are you taking any medication/supplements for the condition? (State dosage, if these are numerous, please add via e mail, including the brands where known)

What other major illnesses have you ahd in the past 10 years? (include surgery or accidents)

What aggravates your current condition?

Does anything alleviate the condition?

FAMILY MEDICAL HISTORY:

Alcoholism	Allergies	Asthma	Cancer	Diabetes
Heart Disease	High Blood Pressure	Seizures	Stroke	Other

Details

GENERAL:

Poor Appetite	Fatigue	Cold Hands	Fevers	Cravings
Heavy Appetite	Tremors	Cold Feet	Sweat Easily	Diabetes
Poor Sleep	Vertigo	Strong Thirst	Night Sweats	Poor Co-ordination
Heavy Sleep	Peculiar Taste/Smell	Bleed Easily	Sudden Energy Drops	Change in Appetite

Details

SKIN & HAIR:

Rashes	Ulcerations	Hives	Itching	Eczema
Acne	Dandruff	Hair Loss	Other	

Details

HEAD, EYES, EARS, NOSE AND THROAT:

Dizziness	Chronic Sore Throat	Migranes	Headaches	Eye Strain
Eye Pain	Sore on Lips/Tongue	Cataracts	Colour Blind	Night Blindness
Spots on eyes	Ear Aches	Poor Hearing	Nose Bleeds	Ringing in Ears
Sinnus Pain	Mucus	Dry Mouth	Dental Problems	Grinding Teeth

Details

CARDIOVASCULAR:

Chest Pain	High Blood Pressure	Irregular Heartbeat	Fainting	Difficulty Breathing Other
Cold hands/feet	Low Blood Pressure	Swelling in hands/feet	Blood Clots	

Details

GASTROINTESTINAL:

Nausea	Vomiting	Diarrhea	Gas	Belching
Black Stools	Bad Breath	Rectal Pain	Hemorrhoids	Constipation
Bloody Stools	Sensitive Abdomen	Pain or Cramps	Laxative use	

Details

UROGENITAL:

Urination Pain	Frequent Urination	Blood in Urine	Urgency to Urinate	Unable to Hold Urine
Kidney Stones	Venereal Disease	Impotency	Other	Night Blindness
Wake up to Urinate				Ringing in Ears

Details

NEURO - PYSCHOLOGICAL:

Seizures	Areas of Numbness	Poor Memory	Concussion	Depression
Anxiety	Bad Temper	Easily Stressed	Treated for emotional problems	
Suicidal	Other problems			

Details

AVERAGE DAILY DIET

Diet - (What foods do you normally eat?)

Breakfast

Lunch

Dinner

HABITS:

Alcohol	Cigarettes	Coffee	Cola	Drugs
Salt	Sugar	Tea	Other	

Exercise - (What exercise do you do?)

Sleep - Describe your sleep pattern (number of hours, how often you wake during the night)

Females only
PREGNANCY & GYNAECOLOGY:

No. of Births	No. of Pregnancies	Premature Births	Miscarriages	Clots
Period (Days)	Birth control	Irregular Periods	Virginal Sores	Breast Lumps
Last PAP	Last Menses	Vaginal Discharge	Age at Last Menses	
Menopause		Changes in body/psyche prior to menstruation		

Menstrual Cycle -Describe length and flow. How do you normally feel during? Do you suffer from PMT?

Age at Menopause - Any problems at the time?

Please sign below to consent for us to hold this information securely on record for 8 years (if you are under 18 a parent/gaurdian will need to sign and the records will be kept until you are 18). We need this information to allow for both the initial and continued consulations. The data will never be shared with anyone without your further written consent.

Signature Printed Name Date