List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	**Strength**	**Frequency Taken**

Allergies to medications

Name the Drug	**Reaction You Had**

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Grandmother** *Maternal*		
Mother					
Sibling(s)			**Grandfather** *Maternal*		
			Grandmother *Paternal*		
			Grandfather *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

HABITS

Do you smoke? ☐YES ☐ NO	If so, how often?	Packs per week?
Do you use Elicit Drugs? ☐YES ☐NO	If so, what type(s)?	