Name: _____ **MEDICAL HISTORY** Date: _____

All Current Medications you are taking:

| Name of Med | Milligrams | Times of day taken | How Long Taken? | Who Prescribes? | Condition: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

What Medications have you taken in the past for Anxiety, Depression, Sleep Problems, ADD/ADHD, etc?

_____

What Medical conditions do you have now?

_____
_____

What Injuries have you experienced?

_____
_____
_____

What prior surgical procedures have you had?

_____
_____
_____

Allergies?

_____

What Medical Conditions Run in Your Family?

_____