advanced ALLERGEase

Medical History

confidential

Name (Last, First, Middle)	Date:

Major Complaint/Health Problem:

How Did This Condition Develop:

How Long Has This Condition Persisted:

What Makes It Better/Worse:

Have You Ever Received Treatment For This Condition: (Circle One) Y N	If Yes, Please Give Date(s) of Treatment:
Where:	By Whom:
What Was the Diagnosis:	What Kind(s) of Treatment:

What Were the Results of the Treatment:

List Any Major Surgeries You've Had:

Date:	Surgery:

Please List Any Substances You Are Allergic To:

List Medications/Supplements You Are Currently Taking:	How Much:	How Often:	For How Long:

Significant Trauma (Auto Accidents, Falls, Etc.):

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