

Medical History

CONFIDENTIAL

Infinite Healing Center - 6638 E. Baseline Rd., Suite 103 Mesa AZ 85206

Name (Last,First,Middle)	Date
Major Complaint/Health Problem	

How Did This Condition Develop?

How Long Has This Condition Persisted?

Is There Anything That Makes It Better?

Is There Anything That Makes It Worse?

Have You Ever Received Treatment For This Condition? <input type="radio"/> Yes <input type="radio"/> No	If Yes When?
Where?	By Whom?
What Was The Diagnosis?	What Kind(s) Of Treatment?
What Were The Results Of The Treatment?	

List Any Substances That You Are Allergic To:

List Any Medications That You Are Currently Taking:	Strength	How Many Per Day	For How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Any Major Surgeries You Have Had:	
Date Problem/Surgery	
_____	_____
_____	_____
_____	_____

Significant Trauma (Auto Accidents, Falls Etc)

Significant Illnesses (Please Check All That Apply)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other Explain: _____		