Integrative Family Health Associates

Patient Medical History

Name: ______________________ Today's Date: ______________

Date of Birth: ______________________

Past Medical History (choose all that apply)

- ☐ Anemia
- ☐ Blood Clots
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes
- ☐ Gastritis
- ☐ Gout
- ☐ Hemorrhoids
- ☐ HIV/AIDS
- ☐ Kidney Infection
- ☐ Lung Disorders
- ☐ Nausea/Diarrhea
- ☐ Obesity
- ☐ Pneumonia
- ☐ Scleroderma
- ☐ Stomach Ulcers
- ☐ Vascular Disease
- ☐ Others (please specify)
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Coronary Heart Disease
- ☐ Fibromyalgia
- ☐ Gastroenteritis
- ☐ Headaches
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Lupus
- ☐ Neck Pain
- ☐ Pancreatitis
- ☐ Pregnancy
- ☐ Seizures
- ☐ Stroke/TIA
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Frequent Urination/Jaundice
- ☐ Gastro Esophageal Reflux
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Kidney Failure
- ☐ Low Back Problems
- ☐ Migraines
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Psychiatric Disorder
- ☐ Sleep Apnea
- ☐ Thyroid Disease

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Past Surgeries

Ailment: ______________________ Date: ______________

Ailment: ______________________ Date: ______________

Ailment: ______________________ Date: ______________

Ailment: ______________________ Date: ______________

Current Medications

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Phone: (708) 482-1099
Fax: (708) 482-0335

4727 Willow Springs Road
Suite 3S
La Grange, IL 60525

Integrative Family Health Associates

Known Allergies

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Family History

- ☐ Anemia — Relation: ____________________
- ☐ Bleeding Problem ____________________
- ☐ Cancer ____________________
- ☐ Diabetes ____________________
- ☐ Epilepsy ____________________
- ☐ Fibromyalgia ____________________
- ☐ Heart Disease ____________________
- ☐ Hypertension ____________________
- ☐ Kidney Problems ____________________
- ☐ Migraines ____________________
- ☐ Muscle Diseases ____________________
- ☐ Nerve Problems ____________________
- ☐ Osteoporosis ____________________
- ☐ Psych Disorders ____________________
- ☐ Stroke ____________________
- ☐ Thyroid Problems ____________________
- ☐ Others (please specify) ____________________

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Personal Information

Job/Profession: ____________________

Marital Status: __________ Number of children: __________

Exercise (what/how often) ____________________

Are you sexually active? __________ Number of partners? __________

Do you drink alcohol? __________ How often? __________

Do you drink caffeine? __________ How often? __________

Did you ever use tobacco? __________ How often? __________

Do you still use tobacco? __________ How often? __________

Recreational drugs? __________ How often? __________