DR. BARBARA BROWN, reg. #3461

PATIENT HEALTH HISTORY:

(Please fill out to the best of your ability, or circle anything that relates to you)

Patient Name: ____

Date: ____

TRAUMA:

Motor Vehicle Accidents:

Date: _______________

Injuries sustained:

Date: _______________

Injuries sustained:

Surgery/hospitalization:

Falls/accidents:

Fractures/sprains:

Head injuries/concussions:

ALLERGIES (medication or other):

DENTAL WORK (root canals, extractions, fillings or other):

MEDICATIONS you are presently taking, and for what:

DIGESTIVE (constipation, diarrhea, ulcers, food sensitivities, irritable bowel, acid reflux, or other):

CARDIOVASCULAR:
Heart conditions:

Blood pressure **high**/**norm**/**low**
Cholesterol **high**/**normal**:
History of stroke or heart attack:
Family history:

WOMEN (menstrual pain, dysfunction, endometriosis, hysterectomy, cysts, hormonal imbalance or other):

Pregnancy: (**yes**/**no**, how many ____)
Complications:

MEN (prostate, pelvic pain, erectile dysfunction or other):

HEADACHES (migraines, tension-type, jaw/TMJ):

SLEEP DISORDERS:

EAR/EYE/NOSE/THROAT (tinnitus, pain, sinus infections or other):

SIGNIFICANT STRESS:

DECREASED ENERGY: **yes/no**

FREQUENT COLDS: **yes/no**

THYROID IMBALANCE: **yes/no**

FAMILY HISTORY MEDICAL CONDITIONS:

OTHER: