Prashanti Clinic

MEDICAL HISTORY

Name : Male/Female: Age: Date:

Present Problem :

Prior treatment for current problem :

		Patient History		Family History			Remarks
		Yes	No	Yes	No	Relationship	
1	Diabetes						
2	Seizures						
3	Headaches						
4	Tremor						
5	Heart Disease						
6	Sleep Disturbances						
7	Difficulty in sleeping						
8	Daytime sleepness						
9	Halucination						
10	Weight Lost						
11	Weight Gain						
12	Memory Problems						
13	Weakness						
14	Trouble walking						
15	Balance Problems						
16	Palpitations						
17	Shortness of breath						
18	Ringing in your ears						

19	Current Tobacco use						If yes: How many per Day How many years When did you quit
20	Alcoho use:						If yes: How many drinks per Day Do you drink beer, wine or liquor ?
21	Drug Use:						Type:

Allergies :

Previous Serious illness or Hospitalizations:

Previous Surgeries :