THE CENTER FOR INTEGRATIVE MEDICINE

81 Hall St. Concord, NH 03301 (603) 228-7600 fax 228-7320

MEDICAL HISTORY FORM

Name: ____________________________________ PCP: ___________________________________

Date: _____________________________________ Referred by: _____________________________

Age: ______________________________________ Date of Birth: ___________________________

Please state your reason for consulting The Center for Integrative Medicine: ______________________

____

____

What is the duration of this problem? What other health care options have you tried for this problem?

____

____

<table>
<tr><td>ILLNESS & MEDICAL HISTORY:
1. ____
2. ____
3. ____
4. ____
5. _______________________________________</td><td>SURGERIES (with dates):
1. _____________________________________
2. _____________________________________
3. _____________________________________
4. _____________________________________
5. _____________________________________</td></tr>
<tr><td>CURRENT MEDICATIONS & SUPPLEMENTS :
1. _______________________________________
2.____
3. ____
4. ____
5. ____</td><td>FAMILY HISTORY:
1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
Any family members w/ heart attack or stroke at less than 55 yrs . of age? ______________</td></tr>
<tr><td>DRUG / MEDICATION ALLERGIES:
1. ____
2. ____
3. ____
4. ____
ENVIRONMENTAL & FOOD ALLERGIES
1. ____
2. ____
3. ____</td><td>LIFESTYLE:
cigarettes ________pack/day
caffeine ________drinks/day
alcohol ________ drinks/day
recreational drugs _______________________
exercise _________ times/week
Type of exercise _______________________
sleep ________________ hr/night
relaxation/meditation practice? _____________
spiritual practice? ________________________</td></tr>
</table>

Please tell us what is *great* in your life ____

____