

## *Medical History Form*

**Name:**

**Today's Date:**

**Date of Birth:**

**E-mail Address:**

**Past Illnesses or Symptoms:**

1.

2.

3.

4.

5.

**Surgeries:**

1.

2.

3.

**Allergies:**

1.

2.

3.

**Current Illnesses and Symptoms:**

1.

2.

3.

4.

5.

6.

**Please List All Current Medications:**

1.

2.

3.

4.

5.

6.

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