Medical History Form

Full Name

Date of Birth

Title: Mr/Mrs/Ms/Miss

Date

Address

Telephone:
Mobile:

Email:

How did you hear about the Garden of health?

G.P's Name and Address

Are you currently seeing your Doctor? yes/no
Why?

List of Medication:

List all **past** medical problems giving approx dates:

List all **past** surgical procedures giving approx dates:

Would you class the amount of antibiotics you have taken to date to be:
Low Average High

Are you seeing any other healthcare practitioners or therapists at the moment? yes/no

Please list therapists and treatment:

Please list any nutritional, vitamin or mineral supplements you take:

Please list any herbs or homeopathic remedies you take:

Are you pregnant? yes/no

Do you suffer from any of the following? High Blood Pressure
Heart Problems
Abdominal Hernia
Haemorrhoids
Renal Insufficiency
Cirrhosis of the liver

Do you have a pace maker? yes/no

Do you have any implanted organs? yes/no

Have you had an epileptic fit? yes/no

Do you have a family history of any of the following and please state how sufferer is related to you:
Heart Disease

Cancer

Diabetes

Crohn's disease

Ulcerative Colitis

Any other condition which you feel may be relevant:

Do you smoke? Yes/no How many do you smoke a day?

Do you drink alcohol? How much in a week?

Do you exercise? Yes/no
If yes, what do you do and how often?

How would you describe your lifestyle? Sedentary/Average/Active/Very Active

Do you drink tea and coffee? yes/no
How much of each do you drink in a day?

Do you drink water? yes/no
How much do you drink in a day?

Give an example of a typical days food for you:

Please tick any of the following conditions that affect you now or have in the past

Gastro-intestinal system

Abdominal pain	Crohn's Disease	Rectal Itching
Chronic Heartburn	Indigestion	Rectal Bleeding
Constipation	Haemorrhoids	Mucous in Stools
Diarrhoea	Fissures/Fistulas	Excessive Gas
Colitis	Vomiting of Blood	Cancer
Diverticulitis	Diabetes	Appendix Removed
Abdominal Bloating	Gall Bladder Disease	Flatulence
Liver trouble	Ulcerative Colitis	Burping

How often do you have a bowel movement?

What is the colour and consistency?

Have you had any part of the colon removed?

Any tests or investigations?

Colonscopy	Endoscopy	Other

Respiratory

Shortness of breath	Bronchitis	Sinus Problems
Chronic cough	Asthma	Emphysema
Hay fever	Pains or Tightness	

Skin

Bruises easily	Rash	Psoriasis
Dryness	Acne	Itching
Eczema	Dermatitis	Fungal infections

Urinary

Cystitis	Prostate trouble	Kidney infection
Painful urination	Kidney Stones	Thrush
Urgency to urinate		

Muscles and Joints

Arthritis	Neck pain	Lower back pain
Swollen joints	Muscle Weakness	Muscle paralysis

Cardiovascular

High Blood Pressure	Angina	Cold hands and feet
Low Blood Pressure	Poor circulation	Rapid/irregular heartbeat
Tingling		Numbness in hands/feet

Ears

Deafness	Itching	Recurring infections
Excessive wax	Pain	Fluid in ears

Eyes

Failing vision	Double vision	Watering
Blurred vision	Spots on vision	Night blindness

Mouth and Throat

Bad breath	Bleeding gums	Blisters/ulcers
Coated tongue	Dry mouth	Persistent cough

Emotional/Nervous System

Irritability	Panic attacks	Persistent headaches
Inability to concentrate	Fatigue	Nervous exhaustion
Mood swings	Insomnia	Depression
Poor memory	Lethargy	

Women

Premenstrual tension	Endometriosis	Polycystic Ovaries
Breast Pain	Failure to menstruate	Extremely heavy flow
Vaginal discharge	Menstrual cramping	Too frequent periods

Please give any other relevant information below:

Name ……

Signature …… Date ……