KSHULS
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NEW PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth _____ Today's Date: _____
Reason for therapy_____

Personal Medical History Have you ever had any of the following conditions? Check if yes

__Anemia
__Arthritis
__Asthma
__Cancer
__Chronic Obstructive Pulmonary Disease
__Clotting Disorder
__Congestive Heart Failure
__Crohn"s Disease
__Depression
__Diabetes
__Emphysema
__Endocrine Problems
__GERD
__Glaucoma
__Hepatitis
__HIV/AIDS
__Hypertension
__Kidney Disease
__Myocardial Infarction
__Peptic Ulcer Disease
__Seizures
__Stroke
__Ulcerative Colitis

Personal Surgical History Have you had one of these surgeries? Check if yes

__Adrenal Gland Surgery
__Appendectomy
__Bariatric Surgery
__Bladder Surgery
__Breast Surgery
__Cesarean Section
__Cholecsystectomy
__Colon Surgery
__Coronary Artery Bypass Graft
__Esophageal Surgery
__Gastric Bypass Surgery
__Hemorrhoid Surgery
__Hernia Repair
__Hysterectomy
__Kidney Surgery
__Neck Surgery
__Prostate Surgery
__Small Intestine Surgery
__Spine Surgery
__Stomach Surgery
__Throid Surgery

List names and dates of surgeries

_____
_____
_____

Medications/Supplements (Please list if 5 or fewer, other wise, please bring list or spreadsheet on separate page

_____
_____

Allergies/sensitivities

_____
_____
_____

Family History Has anyone in your family had any of the following conditions? Check if yes and indicate relationship to you

__Cancer _____ __Diabetes _____
Please specify type _____
__Arthritis _____