LAKEVIEW INTEGRATIVE MEDICINE

PATIENT MEDICAL HISTORY FORM

- **GENERAL INFORMATION**

Name:

Birthdate: Age: Sex:

eMail: Tel: Address:

Education: Profession: Sports: Hobbies:

- **HEALTH HISTORY QUESTIONS**

Current Medications: Current Supplements:

Chief complaints in order of importance to you:

Emotional or personal factors that may have affected your health:

Detailed narrative of your health history and medical issues since birth:

List all diagnoses given to you in a timeline sequence and your personal opinions:

List your opinion on what you think has happened to your health:

List all health care providers you have consulted and their opinions and treatments:

List any treatments, medications or supplements that improved your health:

List any treatments, medications or supplements that decreased your health:

List previous medications:

List previous medical procedures or surgeries:

List previous lab tests and imaging results:

List any exposure to environmental, industrial or toxic compounds:

List previous infections (excluding common colds):

- **PERSONAL OPINION QUESTIONS**

What you consider a realistic time window to see changes in your health under our care?

What are your expectations from us?

What specific health improvements would you consider a successful outcome in your health?