

PATIENT HEALTH HISTORY

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Present Health and Wellness Concerns: _____

Please list current prescription medications: _____

Please list any vitamins, herbs, over the counter medications and any other supplements you are currently taking:

Please check if you currently have or have had any of the following conditions in the past:

	Yes	Date Resolved		Yes	Date Resolved
Alcoholism/ Drug Addiction			Hepatitis		
Allergies			High/ Low Blood Pressure		
Anemia			HIV/AIDS		
Arthritis			Kidney Disease		
Asthma			Mental Illness		
Cancer			Numbness and/ or Tingling		
Depression			Pain		
Diabetes			Pregnancy		
Epilepsy			Skin Problems		
Headaches			Stroke		
Heart Disease			Tuberculosis		

Please list any severe or life threatening allergies: _____

Do you exercise regularly? _____ If so, please describe and include what, how long, and how often you are currently exercising.

Please list any current dietary restrictions or special diets: _____

Please list hospitalizations, serious illnesses, and injuries: _____
