



# The Center For Reproductive Healing

## Medical History

CONFIDENTIAL

The Center for Reproductive Healing ■ 44 W. Market Street ■ Marietta, PA 17547  
www.ReproductiveHealing.com

Phone: 1-877-619-2006

NAME (LAST, FIRST, MIDDLE)	DATE
----------------------------	------

MAJOR COMPLAINT/HEALTH PROBLEM

-----

-----

HOW DID THIS CONDITION DEVELOP?

-----

-----

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHEN?
---	---------------

WHERE?	BY WHOM?
--------	----------

WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?
-------------------------	----------------------------

WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD: DATE	PROBLEM/SURGERY
_____	_____
_____	_____
_____	_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

-----

-----

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	