WILLIAM BECKETT & ASSOCIATES
MEDICAL HISTORY

NAME ____

HEIGHT ______________________ WEIGHT ______________________

DATE OF LAST PHYSICAL EXAMINATION ______________________

DOCTOR ____

ADDRESS ____

PLEASE DESCRIBE CHIEF MEDICAL/PHYSICAL COMPLAINTS OR CONDITIONS

____

ARE YOU CURRENTLY BEING TREATED FOR THIS? ______________________
CHILDREN ONLY: ARE IMMUNIZATIONS UP TO DATE? ______________________

____

ARE YOU ON ANY MEDICATIONS? IF SO, PLEASE LIST

______________ ______________ ______________
______________ ______________ ______________

PLEASE DESCRIBE ANY SIDE EFFECTS

____
____

ARE YOU TAKING ANY NATURAL SUPPLEMENTS? IF SO, PLEASE LIST

____
____

DO YOU HAVE ANY ALLERGIES OR DRUG SENSITIVITIES? IF SO, PLEASE DESCRIBE

____

FAMILY HISTORY

PLEASE PLACE CHECKMARK ON THE LEFT IF A CLOSE FAMILY MEMBER (MOTHER, FATHER, SISTER, BROTHER, AUNT, ETC.) HAS HAD A PROBLEM WITH THE FOLLOWING. INDICATE ON THE RIGHT THEIR RELATIONSHIP TO YOU.

__________ ALCOHOLISM ______________________
__________ ALLERGIES ______________________
__________ MENTAL RETARDATION ______________________
__________ OBESITY ______________________
__________ DEGENERATIVE DISEASE ______________________
__________ MENTAL HEALTH PROBLEMS ______________________
__________ SUICIDE ______________________
__________ CANCER ______________________
__________ DIABETES ______________________
__________ EPILEPSY ______________________
__________ HIGH BLOOD PRESSURE ______________________
__________ HEART TROUBLE ______________________

MEDICAL CONDITIONS AND SYMPTOMS

PAST	NOW	NEVER	
_____	_____	_____	ARTHRITIS
_____	_____	_____	ANXIETY
_____	_____	_____	ANGER OUTBURSTS
_____	_____	_____	ASTHMA
_____	_____	_____	BACKACHES
_____	_____	_____	BINGEING
_____	_____	_____	BARBITURATES
_____	_____	_____	BROKEN SLEEP
_____	_____	_____	CANCER
_____	_____	_____	CHRONIC PAIN
_____	_____	_____	CONSTIPATION
_____	_____	_____	DEPERSONALIZATION
_____	_____	_____	“GOING CRAZY” SENSATIONS
_____	_____	_____	DEPRESSION
_____	_____	_____	DIABETES
_____	_____	_____	DIARRHEA
_____	_____	_____	DIFFICULTY GOING TO SLEEP
_____	_____	_____	DIFFICULTY STAYING ASLEEP
_____	_____	_____	DIZZINESS
_____	_____	_____	DRUG REACTIONS
_____	_____	_____	EARLY AM AWAKENING
_____	_____	_____	EMOTIONAL UPSETS
_____	_____	_____	EPILEPSY
_____	_____	_____	CAN’T WORK UNDER PRESSURE
_____	_____	_____	COLOR BLIND
_____	_____	_____	EXHAUSTION
_____	_____	_____	FAINTING SPELLS
_____	_____	_____	NERVOUS BREAKDOWN
_____	_____	_____	NERVES
_____	_____	_____	NERVOUSNESS
_____	_____	_____	OVEREATING
_____	_____	_____	STOMACH UPSETS
_____	_____	_____	FROM FOOD
_____	_____	_____	FROM MEDICINE
_____	_____	_____	FROM LIQUOR

PAST	NOW	NEVER	
_____	_____	_____	FAST PULSE
_____	_____	_____	HEART MEDICINE
_____	_____	_____	HORMONES
_____	_____	_____	POOR DIGESTION
_____	_____	_____	POOR APPETITE
_____	_____	_____	TREATMENT FOR MENTAL CONDITION
_____	_____	_____	OTHER DRUGS OR ALCOHOL/FOOD CRAVINGS
_____	_____	_____	CRAVING SWEETS
_____	_____	_____	FATIGUE
_____	_____	_____	HEADACHES
_____	_____	_____	MORNING ______
_____	_____	_____	EVENING _______
_____	_____	_____	HOW LONG_______
_____	_____	_____	HEART PROBLEMS
_____	_____	_____	HALLUCINATIONS
_____	_____	_____	HEARING VOICES
_____	_____	_____	HAND TREMORS
_____	_____	_____	HAY FEVER
_____	_____	_____	INSULIN MEDICATION
_____	_____	_____	ITCHY SKIN
_____	_____	_____	LAXATIVES USED
_____	_____	_____	LEG CRAMPS
_____	_____	_____	LOOSE BOWELS
_____	_____	_____	LOSES TEMPER EASY
_____	_____	_____	MEMORY PROBLEMS
_____	_____	_____	MUCH SWEATING
_____	_____	_____	MOIST PALMS
_____	_____	_____	PERFECTIONIST
_____	_____	_____	REDUCED OR LACK OF SEXUAL DESIRE
_____	_____	_____	SHAKING
_____	_____	_____	SMOKING

PACKS PER DAY __________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN ______________________________________

DATE ___________________________________