**APPENDIX C**
**Medical History**

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|---|---|---|---|---|---|
| **Patient Name:** | | | | **Age:** | |
| **Today's Date:** | | | | | |
| **DOB:** | | | | | |
| **Address:** | | | | | |
| **City** | | **State:** | | **Zip:** | |
| **Primary Phone:** | ( ) | | | | |
| **Work/Other:** | ( ) | | | | |
| **Email:** | | | | | |
| **Send report back to me by:** | _____Email: _____ Regular Mail | | | | |

| **Personal Data** | | | | | |
|---|---|---|---|---|---|
| **Height:** | | **Weight:** | | **Gender:** | **M / F** |
| **Handedness:** | _____ Right | _____ Left | **Blood Type:** | | |
| **Marital** | ___ Single | ___Married | ___ Divorced | ___Separated | ___ Other |

| **Diagnosis - (Name, Type, Stage)** | **Date** |
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| **What are the events that led to the diagnosis?** |
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| **What treatments or therapies have you had to date?** |
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| CURRENT MEDICATIONS LIST | |
|---|---|
| **Medication** | **Dosage** |
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**CURRENT MEDICAL STATUS**

**Please check the ONE that best describes your general health today:**

___Normal activity level, no evidence of disease
___Able to carry on normal activity; minor signs or symptoms of disease
___Able to carry on normal activity with effort; some signs or symptoms of disease
___Cares for self, but unable to carry on normal activity or do active work
___Requires assistance and frequent medical care
___Disabled; requiring special care and assistance

**What else would you like to tell us about?**

_____ _____

Patient Signature Date