Advanced Medical Therapies ~ Patient Medical History

Name_____ **Date**_____

Address_____ **Date of birth**_____

City_____ **State** _____ **Zip.**_____ **Phone (H) (_____)** _____

E-Mail address_____ **Phone (W) (_____)** _____

As these are not considered "secure" communication devices:

Is it acceptable for us to contact you via e-mail? **Yes / No**

Is it acceptable for us to leave messages on a voice mail / answering machine for you? **Yes / No**

Occupation _____ **Employers Name:** _____

What provider referred you to us? _____

If under 18, Parent or Guardian name(s): _____

Name and phone number of someone we may contact in an

emergency_____

Gender: Male Female

Current height: _____ **Weight:** _____

Medications & Supplements (Name, dose and schedule you take them on if possible):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any past surgeries / hospitalizations: (include approximate date)

_____ _____

_____ _____

_____ _____

Do you have a family history of any of the following diseases: (Check those that apply:)

	Brother/Siste	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

Please list *ALL your known ALLERGIES*; Drug, Food, Insect, Animal, etc. And type of response:

_____

_____

_____

What are your goals of therapy at AMT?

_____

_____

_____

Past Therapies:

IV Therapy: Yes No Any good or bad experiences?

_____

Hyperbaric Oxygen Therapy: Yes No Any positive or negative experiences?

_____

Sauna: Yes No Any positive or negative experiences?

_____

Hyperthermia: Yes No Any positive or negative experiences?

_____

What else would you like us to know about you and your health:

_____

_____

_____