HEARTLIGHT WELLNESS OF SANTA FE LLC
CONFIDENTIAL

MEDICAL HISTORY

PATIENT NAME _______________________________ Birth Date ________________

Although HeartLight Wellness of Santa Fe LLC treats patients with acupuncture, therapeutic hypnotherapy, energetic allergy work and digestive therapy we need to assess health problems that you may have, or medication that you may be taking. These factors could have an important inter-relationship with the treatment you will receive.

Thank you for answering the following questions:

Are you under a physician's care now? Yes/No If yes, please explain: ______________________________

Have you ever been hospitalized or had major surgery? Yes/No If yes, please explain: ______________________________

Have you ever had a serious head or neck injury? Yes/No If yes, please explain: ______________________________

Are you taking any medications, pills, or drugs? Yes/No If yes, please explain: ______________________________

Do you take, or have you taken, Phen-Fen or Redux? Yes/No Are you on a special diet? Yes/No What Kind? ______________

Do you use tobacco? Yes/No Do you use controlled substances? Yes/No What Kind? _______

Do you need to pre-medicate? Yes/No If yes, please explain: ______________________________

WOMEN: Irregular/abnormal bleeding? Yes/No PMS Yes/No Cramps Yes/No Clots Yes/No Birth Control Yes/No

MEN: Low Testosterone Yes/No Enlarged Prostate Yes/No Testicular Cancer Yes/No Erectile Dysfunction Yes/No Other?

ALLERGIES: Pollen Yes/No Foods Yes/No Drugs Yes/No Mold Yes/No Environmental Yes/No Pets Yes/No

OTHER: Yes/No If yes, please explain: ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes/No	Diarrhea	Yes/No	Hemorrhoids	Yes/No	Renal Dialysis	Yes/No
Anaphylaxis	Yes/No	Depression	Yes/No	Hemophilia	Yes/No	Rheumatic Fever	Yes/No
Anemia	Yes/No	Diverticulosis	Yes/No	Hepatitis A	Yes/No	Rheumatism	Yes/No
Angina	Yes/No	Diabetes	Yes/No	Hepatitis B or C	Yes/No	Scarlet Fever	Yes/No
Arthritis/Gout	Yes/No	Drug Addiction	Yes/No	Herpes: Type 1 or 2	Yes/No	Shingles	Yes/No
Artificial Joint	Yes/No	Easily Frustrated	Yes/No	High Blood Pressure	Yes/No	Sickle Cell Disease	Yes/No
Asthma	Yes/No	Emphysema	Yes/No	Hives or Rash	Yes/No	Sinus Trouble	Yes/No
Blood Disease	Yes/No	Epilepsy or Seizures	Yes/No	Hypoglycemia	Yes/No	Spina Bifida	Yes/No
Breathing Problem	Yes/No	Excessive Bleeding	Yes/No	Irregular Heartbeat	Yes/No	Stomach Issues	Yes/No
Bruise Easily	Yes/No	Excessive Thirst	Yes/No	Kidney Problems	Yes/No	Stroke	Yes/No
Cancer	Yes/No	Fainting Spells/Dizziness	Yes/No	Leukemia	Yes/No	Suicidal Thoughts	Yes/No
Chemotherapy	Yes/No	Fibromyalgia	Yes/No	Liver Disease	Yes/No	Swelling of Limbs	Yes/No
Chest Pains	Yes/No	Frequent Headaches	Yes/No	Low Blood Pressure	Yes/No	Thyroid Disease	Yes/No
Cold Sores	Yes/No	Glaucoma	Yes/No	Lung Disease	Yes/No	Tonsillitis	Yes/No
Cong.Heart Disorders	Yes/No	Hay Fever /Coughing	Yes/No	Mitral Valve Prolapse	Yes/No	Tuberculosis	Yes/No
Convulsions	Yes/No	Heart Attack/Failure	Yes/No	Parathyroid Disease	Yes/No	Tumors or Growths	Yes/No
Constipation	Yes/No	Heart Murmur	Yes/No	Psychiatric Care	Yes/No	Ulcers	Yes/No
COPD	Yes/No	Heart Pace Maker	Yes/No	Radiation Trmt.	Yes/No	Venereal Disease	Yes/No
Cortisone Medicine	Yes/No	Heart Trouble/Disease	Yes/No	Recent Weight Loss	Yes/No	Yellow Jaundice	Yes/No

Explain any conditions you have answered YES to above____

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Have you ever had any serious illness not listed above? Yes/No - If yes, please explain: __________________

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I have answered the questions on this form accurately to the best of my knowledge, and I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the HeartLight Wellness of Santa Fe LLC in writing if there are any changes in your medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _________________________________DATE ____________

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