Please list additional complaints or problems:

	Problem	Onset	Frequency	Severity
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please list any medications or supplements you are currently taking:

	Supplement / Medication	Prescribed For	How Long
1.			
2.			
3.			
4.			
5.			
6.			
7.			

How many times and at what ages have you taken the following:

	Infancy (Birth to 1 Year)	Toddler (1-5 Years)	Childhood / Teen (5-18 Years)	Adult
Antibiotics				
Steroids				

Known Food Allergies:

Food	Reaction

Environmental Allergies:

_____

_____

_____