Margaret A. Sheehan, M.D.
Highlands Health and Healing
3441 Tennyson St, Denver, CO 80211

Name:______________________________ Age:__________ Date of Birth:__________

Parent's names (if applicable)____

Address:____
Street Address City State Zip Code

Phone: (H) __________________ (Cell) _________________ (Work)_______________

Preferred location to contact you:_________________ E-mail:_____________________

Marital Status: S M Sep. D W Other Number of Siblings:______

Occupation:____________________________ Referred by:_________________________

Primary Care Physician:______________________________

Major Complaints in order of importance

Complaint	Since	Suspected Cause
___________________	____________	__________________________________
___________________	____________	__________________________________
____________________	____________	_________________________________

What medications and supplements are you(or your child) taking

Medication	Dose	Since	Adverse Effects
__________________	_____________	__________	__________________
___________________	_____________	__________	__________________
___________________	______________	__________	__________________

What operations have you (or your child) had

Operation When Complications

____________________ ____________
____

____________________ ____________ ______________________________

Any major injuries?____

Which of the following conditions have you (or your child had)- please circle

Abscesses	Depression	Hepatitis	Parasites
Acne	Diabetes	Infertility	PID
Alcoholism	Digestive Problems	Ingrown Toenails	Pleurisy
Allergies	Eczema	Joint Pain	Pneumonia
Attention Problems	Endometriosis	Growing pains	Prostate problems
Anxiety	Erectile Dysfunction	Kidney Disease	Bedwetting
Asthma	Fibromyalgia	Menstrual Problems	Psoriasis
Cancer	Flu	Miscarriage	Respiratory Disease
Canker sores	Gall Stones	Mononucleosis	Root Canal
Chicken Pox	Genital Herpes	Mood problems	Scarlet Fever
Cradle Cap	Goiter	Learning Problems	Sexual Abuse
Cold Sores	Gout	Behavior Problems	Rheumatic Fever
Colic	Hay Fever	Hyperactivity	Sinusitis
Diaper Rash	Headaches	Mumps	Chronic sniffles
Diarrhea	Heart Disease	Ear infections	Skin Disease
Tantrums	Early Puberty	Styes	Sun Stroke
Thyroid problems	Tonsillitis	Tuberculosis	Uterine Fibroids
Vaginitis	Nightmares	Venereal Disease	Venereal Warts
Warts	Whooping Cough	Worms	Foot Odor
Fears/Phobias	Finicky eating	Weight loss	

Any other conditions? ____
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Any of the above conditions that you (or your child) have never recovered from?_______

When was your (or your child's) last physical exam? ____________________________

Any adverse effects from vaccines?____

How many times have you (or your child) taken antibiotics?_______________________

Any known allergies to food, drugs, environment? _______________________________

General Family History: Please comment on the health condition of close relatives:
____
____
__

Indicate below which of the following ailments have affected your relatives

Alcoholism	Cancer	Gonorrhea	Syphilis	
Allergies	Depression	Gout	Paralysis	Tuberculosis
Arthritis	Diabetes	Hay Fever	Pneumonia	
Asthma	Epilepsy	Heart Disease	Skin Disease	

Are you familiar with or have you ever had Homeopathic treatment?_____________

If yes, what remedies have you taken and what remedies have helped?

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Please add anything else that you feel is important or may be helpful: