HEALTH HISTORY FORM

NAME: _____ DATE: _____

PLEASE CHECK ALL THAT APPLY TO YOUR MEDICAL HISTORY

ADD / ADHD	☐	VISION DISORDERS	☐	HYPERTENSION	☐
BRONCHITIS	☐	EPILEPSY	☐	SINUSITIS	☐
EAR INFECTIONS	☐	HEADACHES / MIGRANES	☐	STOMACH DISORDERS	☐
HEART DISEASE / DEFECT	☐	HIGH CHOLESTROL	☐	DIABETES	☐
KIDNEY DISEASE	☐	SICKLE CELL ANEMIA	☐	GERD	☐
SKIN CONDITION	☐	SLEEP DISORDERS	☐	INTESTINAL DISORDER	☐
ARTHIRITIS	☐	ASTHMA	☐	UTI	☐
CHEMICAL DEPENDENCY	☐	FAINTING	☐	BLEEDING / CLOTTING	☐
		HEARING DISORDER	☐	MUSCLE DISORDERS	☐

CANCER (Please specify) _____

OTHER (Please specify) _____

IMMUNIZATIONS: TETANUS _____ PNEUMONIA _____

DATE DATE

SURGICAL HISTORY

PROCEDURE	DATE	LOCATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE BACK OF THIS FORM.

SOCIAL HISTORY (CHECK ALL THAT APPLY)

COFFEE	☐	CURRENT SMOKER	☐	ALCOHOL	☐
TEA	☐	FORMER SMOKER	☐	STREET DRUGS	☐
SOFT DRINKS	☐	NON-SMOKER	☐		

FAMILY HISTORY

	Y	N	RELATION	TYPE
CANCER				
CANCER				
HIGH CHOLESTEROL				
HYPERTENSION				
HEART ATTACK / DISEASE				
DIABETES				
KIDNEY DISEASE				
SUICIDE / DEPRESSION				
CHEMICAL DEPENDENCY				

MOTHER / DECEASED Y N CAUSE OF DEATH: _____

FATHER / DECEASED Y N CAUSE OF DEATH: _____

ALLERGIES

PLEASE LIST ALL MEDICATION, FOOD, PLANT, AND OTHER ALLERGIES

ALL MEDICATIONS

NAME OF MEDICATION	STRENGTH	FREQUENCY