PERSONAL HEALTH HISTORY

DATE _____

NAME _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE OR HAVE HAD:

Anemia/Blood Disease	☐ YES	☐ NO
Sickle Cell Anemia	☐ YES	☐ NO
Bronchitis/ Chronic Cough	☐ YES	☐ NO
Loss of Consciousness/ Dizziness	☐ YES	☐ NO
Hepatitis/ Liver Disease/ Jaundice	☐ YES	☐ NO
Neck/ Back Problem	☐ YES	☐ NO
Cancer/ Tumor/ Leukemia	☐ YES	☐ NO
Arthritis/ Rheumatism	☐ YES	☐ NO
Color Blindness/ Glaucoma	☐ YES	☐ NO
Heart Disease/ Heart Murmur	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Sinus Problems/ Hay Fever	☐ YES	☐ NO
Immune Deficiency Syndrome	☐ YES	☐ NO
Removal of Spleen	☐ YES	☐ NO
Gall Bladder Surgery	☐ YES	☐ NO
Hernia Repair	☐ YES	☐ NO
Rectal/ Bowel Surgery	☐ YES	☐ NO
Major Bone/ Joint Surgery	☐ YES	☐ NO

Prostate Surgery ☐ YES ☐ NO

Pregnancies ☐ YES ☐ NO

Allergies ☐ YES ☐ NO

Tonsils/Adenoids/ Ear Surgery ☐ YES ☐ NO

Asthma/ Emphysema ☐ YES ☐ NO

TB/ History of Positive Skin Test ☐ YES ☐ NO

Seizures/ Epilepsy ☐ YES ☐ NO

Frequent or Severe Headaches ☐ YES ☐ NO

Thyroid Disease/ Goiter ☐ YES ☐ NO

Kidney Disease/ Kidney Stones ☐ YES ☐ NO

Knee or Joint Problems ☐ YES ☐ NO

Stroke/ Paralysis ☐ YES ☐ NO

Deafness/ Hearing Loss/ Ringing in the ears ☐ YES ☐ NO

Ulcer/ Digestive/ Problems Bowel Disease ☐ YES ☐ NO

History of Alcohol/ Drug Problems ☐ YES ☐ NO

Gyn(female) Problems/infections ☐ YES ☐ NO

Hysterectomy/ Gyn(female) Surgery ☐ YES ☐ NO

Ulcers/ Stomach Surgery ☐ YES ☐ NO

Appendectomy ☐ YES ☐ NO

Breast Surgery ☐ YES ☐ NO

Heart/ Lung Surgery ☐ YES ☐ NO

Cataract Surgery ☐ YES ☐ NO

CURRENT MEDICATIONS:

PLEASE LIST ANY OTHER MEDICAL/SURGICAL CONDITION, OR COMMENT ON ANY OF THE ABOVE:

FAMILY HISTORY: MOTHER

CURRENT AGE (or if deceased give date of death)

ILLNESSES

GENERAL HEALTH

FAMILY HISTORY: FATHER

CURRENT AGE (or if deceased give date of death)

ILLNESSES

GENERAL HEALTH

FAMILY HISTORY: SIBLINGS

CURRENT AGE (or if deceased give date of death)

GENDER

ILLNESSES

GENERAL HEALTH

FAMILY HISTORY: SIBLINGS

CURRENT AGE (or if deceased give date of death)

GENDER

ILLNESSES

GENERAL HEALTH

Please include cancer, diabetes, heart attacks, blood pressure, strokes, TB and any important illnesses.

DO YOU SMOKE?

CURRENTLY ☐ YES ☐ NO

HOW MUCH?

NUMBER YEARS?

☐ CIGARETTES ☐ CIGARS ☐ PIPE

DO YOU DRINK ALCOHOLIC BEVERAGES?

CURRENTLY ☐ YES ☐ NO

WHAT KIND? _____

HOW OFTEN? _____

FOR FEMALES ONLY:

ARE YOU PREGNANT? ☐ YES ☐ NO

DATE OF LAST MENSTRUAL CYCLE? _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY

SIGNATURE _____

DATE _____