



Health History Form

Full Name _____ M ___ F ___ Date _____
 Medical Allergies _____

Disease (Check all that apply)	Self	Mom	Dad	Sis	Bro	GM	GF	Hospitalizations
Allergic Rhinitis/Hay Fever								Reason: _____ Yr.: _____
Anemia								Reason: _____ Yr.: _____
Arthritis								Reason: _____ Yr.: _____
Asthma								Reason: _____ Yr.: _____
Blood Transfusion								Reason: _____ Yr.: _____
Breast Cancer								Reason: _____ Yr.: _____
Cataracts								Reason: _____ Yr.: _____
Colon Cancer								Reason: _____ Yr.: _____
Depression/Anxiety/Mental Illness								Surgeries
Diabetes								
Drug/Physical/Alcohol Abuse								_____ Yr.: _____
Emphysema/Lung Problems								_____ Yr.: _____
Endometriosis								_____ Yr.: _____
Hearing Problems								_____ Yr.: _____
Heart Disease/Heart Attacks								_____ Yr.: _____
High Blood Pressure								_____ Yr.: _____
High Cholesterol								Do you use any form of Tobacco?
Irritable Bowel Syndrome								Yes _____ No _____
Kidney Problems								Type & Amount: _____
Migraines								Do you drink Alcoholic Beverages?
Neurological Disease								Yes _____ No _____
Peptic Ulcer Disease/GI Problems								Amount: _____
Positive TB Test/Tuberculosis								Treated for Substance Abuse?
Sexually Transmitted Diseases								Yes _____ No _____
Stroke								When? _____
Thyroid Problems								Sexually Active?
Other:								Yes _____ No _____
Current Medications					Dosage			Frequency
1. _____					_____			_____
2. _____					_____			_____
3. _____					_____			_____
4. _____					_____			_____

Women Only:

Age Menses Began _____ Regular Menses Y ___ N ___ LMP _____ Last PAP _____ Last Mamm _____
 Ob/Gyn Dr _____ Pregnancies _____ Form of Contraception _____

I certify that the above information is correct and true to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____