HEALTH HISTORY FORM

NAME_____ **DOB**_____

PLEASE CHECK ALL THAT APPLY TO YOUR MEDICAL HISTORY

ADD/ADHD	☐	VISION DISORDER	☐	HYPERTENSION	☐
BRONCHITIS	☐	EPILEPSY	☐	SINUSITIS	☐
EAR INFECTIONS	☐	HEADACHES/MIGRAINES	☐	STOMACH DISORDERS	☐
HAY FEVER	☐	HIGH CHOLSETEROL	☐	DIABETES	☐
HEART DISEASE	☐	MONONUCLEOSIS	☐	GERD	☐
HEART DEFECT	☐	SICKLE CELL ANEMIA	☐	INTESTINAL DISORDER	☐
KIDNEY DISEASE	☐	SLEEP DISORDERS	☐	UTI	☐
SKIN CONDITION	☐	ASTHMA	☐	BLEEDING/CLOTTING	☐
ARTHRITIS	☐	FAINTING	☐	MUSCLE DISORDERS	☐
CHEMICAL DEPENDENCY	☐	HEARING DISORDER	☐	SKELETAL DISORDERS	☐

CANCER (PLEASE SPECIFY) _____

OTHER (PLEASE SPECIFY) _____

IMMUNIZATIONS TETANUS _____ PNEUMONIA_____

SURGICAL HISTORY

PROCEDURE	DATE	LOCATION

IF ADDITIONAL SPACE IS NEEDED PLEASE USE BACK OF THIS FORM

SOCIAL HISTORY (CHECK ALL THAT APPLY)

COFFEE	☐	EXERCISE	☐	# PER WEEK_____
TEA	☐	SMOKER	☐	# PER DAY_____
POP	☐	ALCOHOL	☐	# PER WEEK_____

FAMILY HISTORY

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

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	DAILY AMOUNT