HEALTH HISTORY FORM

Name _____ Date of Birth _____ Date Completed _____

FAMILY HEALTH HISTORY: Include age (or age at death) and quality of health (or cause of death).

Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Children _____

HAVE ANY FAMILY MEMBERS HAD: (include aunts, uncles, grandparents)

Diabetes _____ Gout _____
High blood pressure _____ Birth defects _____
Heart disease _____ Kidney disease _____
Cancer (type) _____ Mental illness _____
Epilepsy _____ Heart attack _____
Bleeding problems _____ Stroke _____
Asthma _____ Tuberculosis _____
Goiter _____ Emphysema _____

HOW DO YOU FEEL ABOUT YOUR HEALTH AND STRENGTH IN GENERAL? _____

HAVE YOU EVER HAD:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
1. Serious headaches	☐	☐	14. Ankle swelling	☐	☐	27. Blood transfusion (date :_____)	☐	☐
2. Double vision	☐	☐	15. Stomach ulcer	☐	☐	28. Goiter (thyroid)	☐	☐
3. Hearing trouble	☐	☐	16. Hay fever	☐	☐	29. Pain in legs w/ exercise	☐	☐
4. Ear infections	☐	☐	17. Allergic reaction	☐	☐	30. X-ray treatment-any part of body	☐	☐
5. Chest pains	☐	☐	18. Gallbladder	☐	☐	31. Depression	☐	☐
6. High blood pressure	☐	☐	19. Constipation	☐	☐	32. Mood disorder	☐	☐
7. Heart attack	☐	☐	20. Black/Bloody stools	☐	☐	33. Rash	☐	☐
8. Shortness of breath	☐	☐	21. Stroke	☐	☐	34. Pigmentation changes	☐	☐
9. Asthma	☐	☐	22. Blackout spells	☐	☐	35. Abnormal hair growth	☐	☐
10. Pneumonia	☐	☐	23. Blood in urine	☐	☐	36. Joint pain or stiffness	☐	☐
11. Coughed up blood	☐	☐	24. Anemia	☐	☐	37. Easy bleeding and bruising	☐	☐
12. Daily cough	☐	☐	25. Fatigue	☐	☐	38. Have you had anesthesia before?	☐	☐
13. Change in vision	☐	☐	26. Serious head injury	☐	☐	what type? _____		
						Any complications? _____		

HAVE YOU HAD:	**YES**	**NO**	**NORMAL**	**ABNORMAL**	**DATE IF KNOWN**
X-ray: Stomach	☐	☐	☐	☐	_____
Colon	☐	☐	☐	☐	_____
Gallbladder	☐	☐	☐	☐	_____
Chest	☐	☐	☐	☐	_____
EKG	☐	☐	☐	☐	_____
Tuberculosis skin test	☐	☐	☐	☐	_____
Colonoscopy	☐	☐	☐	☐	_____
Mammogram	☐	☐	☐	☐	_____
Bone density test	☐	☐	☐	☐	_____

HAVE YOU WORKED WITH:

	YES	**NO**
Asbestos	☐	☐
Silica	☐	☐
Chemicals	☐	☐

Do you smoke? Yes ☐ No ☐ How many packs per day? _____ How many years? _____
How many cups of coffee per day? _____
How many ounces of alcohol per week? _____
How many ounces of beer per week? _____
Have you used or do you currently use illicit drugs? _____
Do you abide by a specific diet? _____
How much do you exercise per week? _____hours/week

Type: _____

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WOMEN ONLY

Age periods began _____ Frequency _____
Date of last period _____
Excessive bleeding? _____
Do you take hormone or birth control pills? _____
Pregnancies _____ How many children? _____ Miscarriages _____

CHILDHOOD ILLNESSES/IMMUNIZATIONS AND *APPROXIMATE* DATES:

IMMUNIZATIONS/ILLNESSES:

Measles _____ Mumps _____
Chicken pox _____ Polio _____
Whooping cough _____ Diphtheria _____
Small pox _____

ILLNESSES:

Rheumatic fever _____
Scarlet fever _____

Present weight: _____ Maximum weight: _____
Weight changes in the past 6 months: _____

LIST ANY ALLERGIES (INCLUDING TO MEDICATIONS):

_____
_____

MEDICINES TAKEN WITHIN THE LAST 3 MONTHS:

(Include vitamins, laxatives, aspirin, herbal products and the amount taken per day)

	NAME OF MEDICATION	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		

CURRENT AND PREVIOUS MAJOR ILLNESSES:	DATE	WHERE TREATED?
1.		
2.		
3.		
4.		
5.		
6.		

OPERATIONS AND SURGERIES (MAJOR AND MINOR)

	DATE	WHERE TREATED?	COMPLICATIONS?
1.			
2.			
3.			

HOSPITALIZATIONS (OTHER THAN OPERATIONS):

	DATE	WHERE TREATED?
1.		
2.		
3.		

BROKEN BONES:	DATE	WHERE TREATED?
1.		
2.		
3.		

CURRENT OCCUPATION:

_____

PAST OCCUPATIONS:

1. _____
2. _____
3. _____