

HEALTH HISTORY

Full Name: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Gender: _____ Ethnic Background: _____

Current Health Status: _____

MEDICAL HISTORY:

HAVE YOU HAD? (circle choice)	Yes	NO	HAVE YOU HAD? (circle choice)	Yes	NO
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		
Kidney Disorders			Chicken Pox Illness		

Bladder Disorders			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems-Specify below:		

List any other major diseases, conditions or surgeries not covered above. _____

List any hospitalizations. _____

List any medications you are currently taking. _____

List any medications you are allergic to. _____

HEALTH HABITS:

DO YOU USE THE FOLLOWING?	Yes	NO	DO YOU USE THE FOLLOWING?	Yes	NO
Caffeine			Tobacco		
Alcohol			Illicit Drugs		