HEALTH HISTORY

Patient Name: **DOB:**

Please circle medical diagnosis that apply for both yourself and your family and indicate on the line which family member it applies to (Including the deceased).

	PATIENT		FAMILY (Include deceased members)	WHO
*Anemia	no	yes	yes	_____
*Arthritis	no	yes	yes	_____
*Asthma or Emphysema	no	yes	yes	_____
*Cancer (type or location)	no	yes	yes	_____
*Chronic Headaches	no	yes	yes	_____
*Diabetes	no	yes	yes	_____
*Gastritis or Ulcers	no	yes	yes	_____
*Heart Disease/Murmurs	no	yes	yes	_____
*High Blood Pressure	no	yes	yes	_____
*High Cholesterol	no	yes	yes	_____
*Kidney Failure/Stones	no	yes	yes	_____
*Liver Disease/Alcoholism	no	yes	yes	_____
*Psychiatric Disorders	no	yes	yes	_____
*Sinusitis	no	yes	yes	_____
*Strokes or Seizures	no	yes	yes	_____
*Thyroid Disease	no	yes	yes	_____
*Disease not mentioned	_____			
	_____			

Please list **any Surgeries** you have had in the past with the approximate date.

Please list **any Hospitalizations** with the approximate date and hospital name (if recalled)

Please list **all Medications** you are taking (including over counter), use reverse side if necessary

Please list any **Medication Allergies**

If you have ever **smoked tobacco** or **drink alcohol**, please indicate how much you smoke and for how long, how much you drink, what type, and how often.