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HEALTH HISTORY

Please print in the information below to the best of your ability

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Which hand do you write with: Right_____ Left _____

Primary Physician: _____ Referring Physician: _____

Other Physicians: _____

Pharmacy (Name and Location): _____

Briefly, state the problem you have been referred for:

Past Medical History: (Check any of the following that you are presently or in the past have been under treatment for):

- ☐ Diabetes
- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Failure
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Stroke (Include Mini-Strokes)
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease/Failure
- ☐ Bladder Problems
- ☐ Asthma
- ☐ Emphysema
- ☐ High Cholesterol
- ☐ Cancer (list type or area effected)
- ☐ **All other illnesses:**

_____
_____
_____
_____

Other: (For females, include number of pregnancies and deliveries)

SURGERY: (List type of surgery and date/year)

MEDICATIONS: (PLEASE INCLUDE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION)	**ALLERGIES:**

FAMILY: (Give age and present health and list medical problems. If deceased give age and cause of death.)

Mother: _____ Father: _____

Sisters: _____ Brothers: _____

Others: (Major or hereditary conditions in grandparents, aunts, uncles or cousins) _____

SOCIAL: Marital Status: _____ # in Household: _____ Occupation: _____

Tobacco: ☐ Current ☐ Quit ☐ Never. Number of cigarettes/packs a day: _____ Years smoked: _____

Years Quit: _____ Alcohol use: _____ Drugs: _____ Level of education: _____