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**HEALTH HISTORY FORM**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL HEALTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently or have you been treated for:

 YES NO CONDITION EXPLAIN

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Asthma |  |
|  |  | Bleeding Disorders |  |
|  |  | Blood Pressure |  |
|  |  | Cancer |  |
|  |  | COPD |  |
|  |  | Diabetes |  |
|  |  | Ear/Sinus |  |
|  |  | Fainting |  |
|  |  | Gastro-intestinal Issues |  |
|  |  | Heart Disease |  |
|  |  | Kidney Disease |  |
|  |  | Learning Disorders |  |
|  |  | Menstrual Problems |  |
|  |  | Musculoskeletal Issues |  |
|  |  | Psychological/Psychiatric |  |
|  |  | Seizures |  |
|  |  | Sleep Disorders |  |
|  |  | Stroke |  |
|  |  | Surgery |  |
|  |  | Thyroid Disease |  |
|  |  | Serious Injury |  |
|  |  | Other |  |

List all medications you are currently taking, including over-the-counter drugs and herbal supplements

 MEDICATION DOSAGE REASON

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_