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Health History Form

NAME_____ OCCUPATION_____

Date of Birth_____

PAST ILLNESSES

___Asthma
___Hay Fever
___TB (Tuberculosis)
___Kidney Problems
___Heart Problems
___High Cholesterol
___Rheumatic Fever
___Diabetes
___Stroke
___Cancer – Type_____
___Anemia
___Abnormal Pap Results
___Ulcers
___Mental Illness
___Seizures
___Depression
___Back Problems
___Thyroid Disease
___Gall Stones
___Hepatitis- A B C
___Liver Problems
___Bleeding Problems
___Skin Problems
___Alcohol Problems
___Drug Problems
___Hearing Loss
___Sexually Transmitted Disease
___HIV or AIDS
___Headaches
___Vision Problems
___High Blood Pressure
___Irregular Periods
___Other_____
_____
_____

IMMUNIZATIONS

	Year
___Rubella	_____
___Measles	_____
___Tetanus	_____
___Hepatitis B	_____
___Pneumovax	_____
___Flu Vaccine	_____
___Other	_____

_____
_____
_____

ALLERGIES

Please check any allergies that you have had and write down the reactions.

___Penicillin_____
___Sulfa_____
___Aspirin_____
___Codeine_____
___Bee Stings_____
___Foods_____
_____
_____
Other_____
_____

ALCOHOL USE: Yes_____ No_____ Quit_____
Amount_____ How Often_____

TOBACCO USE: Yes_____ No_____ Quit_____
Type_____ Amount Per Day_____

SURGERIES

___Appendix
___Gall Bladder
___Uterus
___D&C
___Tonsils
___Breast
___Fallopian Tubes
___Ovaries
___Other_____
_____

HOSPITALIZATIONS

Please list dates and reason for each hospitalization

DATE	REASON
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please list any medications you take, both prescription and over-the-counter. Give dosage and how often taken.

DRUG	DOSE	HOW OFTEN