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## HEALTH & HISTORY

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

### PAST SURGICAL HISTORY:

List all surgeries during your lifetime (including date or age when surgery done):

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

### PAST MEDICAL HISTORY:

Circle if you have had any of the following medical problems:

- |                             |                       |
|-----------------------------|-----------------------|
| GLAUCOMA                    | HIATAL HERNIA         |
| MENINGITIS                  | ULCERS                |
| STROKE (CVA OR TIA)         | HEPATITIS             |
| HYDROCEPHALUS               | DIVERTICULITIS        |
| MIGRAINE HEADACHES          | SPASTIC COLON         |
| EPILEPSY (SEIZURES)         | DIABETES MELLITUS     |
| THYROID PROBLEMS            | CANCER TYPE: _____    |
| ASTHMA                      | ANEMIA                |
| EMPHYSEMA                   | KIDNEY INFECTIONS     |
| PNEUMONIA                   | BLADDER INFECTIONS    |
| TUBERCULOSIS                | GONORRHEA OR SYPHILIS |
| BRONCHITIS                  | HERPES                |
| PLEURISY                    | HIV INFECTION         |
| HIGH BLOOD PRESSURE         | SKIN PROBLEMS         |
| HEART MURMUR                | HIVES OR ECZEMA       |
| HEART ATTACK (MI)           | ARTHRITIS             |
| RHEUMATIC FEVER             | NEURITIS OR NEURALGIA |
| ARRHYTHMIA (IRR HEART BEAT) | BURSITIS              |
| BLOCKED ARTERIES            | SCIATICA              |
| WHERE? _____                | SCOLIOSIS             |

### CHILDHOOD ILLNESSES:

- MEASLES: (GERMAN) (10 DAY) \_\_\_\_\_  
 MUMPS \_\_\_\_\_  
 CHICKEN POX \_\_\_\_\_  
 WHOOPING COUGH \_\_\_\_\_

### NERVOUS PROBLEMS:

- ANXIETY \_\_\_\_\_  
 DEPRESSION \_\_\_\_\_

### OTHER ILLNESSES:

HAVE YOU HAD A:	DATE	REASON
CHEST X-RAY	_____	_____
UPPER OR LOWER GI	_____	_____
ULTRASOUND	_____	_____
CT SCAN	_____	_____
MRI	_____	_____
BONE DENSITY	_____	_____
COLONOSCOPY	_____	_____
SIGMOIDOSCOPY	_____	_____
DATE OF LAST MAMMOGRAM	_____	_____

List all prescribed medications and dosages: (Please indicate if NONE).

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

### Do you take the following: (Circle)

- |           |                       |
|-----------|-----------------------|
| ASPIRIN   | BIRTH CONTROL PILLS   |
| TYLENOL   | SLEEPING PILLS        |
| VITAMINS  | LAXATIVES             |
| IBUPROFEN | APPETITE SUPPRESSANTS |

### HOME REMEDIES

### HERBAL MEDICATIONS

WHICH ONES? \_\_\_\_\_

**Vaccinations:** Date of last Tetanus: \_\_\_\_\_ Flu Shot: \_\_\_\_\_ Pneumonia Shot: \_\_\_\_\_ Polio: \_\_\_\_\_

**List all allergies to:** Medications: \_\_\_\_\_ Environment or foods: \_\_\_\_\_

List present occupation: \_\_\_\_\_ Past occupation: \_\_\_\_\_

Places you have lived: \_\_\_\_\_

Highest level of education: \_\_\_\_\_ Religious Preference: \_\_\_\_\_ Active \_\_\_\_\_ Inactive \_\_\_\_\_

Do you see your faith as an important part of your health? Yes \_\_\_\_\_ No \_\_\_\_\_