

PERSONAL HEALTH HISTORY

Name _____ Today's Date _____

Height: _____ Weight: _____ Age: _____

-- Health Habits --	
Check Substances you use	Frequency
Alcohol	
Tobacco	

--Women Only--			
Number of pregnancies		Number of Live Births	
Are you currently pregnant or nursing?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Experienced any recent breast tenderness, lumps, or nipple discharge?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

-- Allergies --	
Name of Drug	Reaction you had

-- Medications --		
Name of Drug	Strength	Frequency Taken

-- Past Surgeries --		
Surgical Procedure Performed	Year	Hospital/Facility/Doctor

-- Conditions --			
Check any/all conditions that you currently have or have had in the past			

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Anemia
<input type="checkbox"/> Anorexia
<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bulemia
<input type="checkbox"/> Cancer
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Goiter
<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hernia
<input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio
<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Stroke
<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Tonsilitis
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Venereal Disease |
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