PERSONAL HEALTH HISTORY

Name____ Today's Date_______________________

Height: ______________________ Weight: ____________ Age: _________ Blood Type:______________

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

--Women Only--					
Number of pregnancies		Number of Live Births		Number of Miscarriages	
Are you currently pregnant or nursing?				☐ Yes ☐ No	
Experienced any recent breast tenderness, lumps, or nipple discharge?				☐ Yes ☐ No	

-- Allergies --	
Name of Drug	Reaction you had

-- Medications --		
Name of Drug	Strength and Frequency	Reason

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

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

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes (Oral or Genital)
- ☐ Other____
- ☐ Other____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ blood clots
- ☐ problems with anesthesia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease