PERSONAL HEALTH HISTORY

Name____Today's Date___________________________

Age___________Birthdate_________________________Height_________________Weight____________________

Occupation____Daytime Phone_________________________________

MEDICAL RECORD Please check (√) all that apply:	Self	Mother	Father	Siblings
Abnormal Electrocardiogram				
Allergies				
Anemia				
Arthritis				
Asthma				
Birth Defects				
Bleeding Tendency				
Blindness				
Broken Bones				
Cancer				
Cataracts				
Chronic Bronchitis				
Cirrhosis of Liver				
Colitis / Irritable Bowel				
Congenital Heart Disease				
Cystitis				
Depression				
Diabetes				
Dizziness / Vertigo				
Ear Infections – Chronic				
Emphysema				
Enlarged Heart				
Epilepsy				
Fibromyalgia				
Glaucoma				
Gall Stones				
Gout				
Goiter				
Hearing Loss				
Heart Murmur / Heart Disease				
Heart Attack				
High Blood Pressure				
High Cholesterol				
Hepatitis / Liver Disease				

MEDICAL RECORD (continued)	Self	Mother	Father	Siblings
Hemorrhoids				
Kidney Infection / Disease				
Kidney Stones				
Lupus Erythematosus				
Migraines				
Multiple Sclerosis				
Osteoporosis				
Prostate Problems				
Rheumatic Fever				
Recurrent Boils				
Sexually Transmitted Disease				
Skin Cancer / Disease				
Stomach or Duodenal Ulcer				
Stroke				
Substance Abuse				
Thyroid (Overactive)				
Thyroid (Underactive)				
Tinnitus				
Varicose Veins				
Other:				

X-RAYS	YES	NO	DATE
Ears			
Sinuses			
Head and Neck			
Skull			
Gall Bladder			
Back			
Chest			
Extremities			
Kidney			
Colon			
Radiation Therapy			
Other:			

(CONTINUED ON OTHER SIDE)

HOSPITALIZATIONS / SURGERIES	DATE

DO YOU? If yes, daily consumption:	Yes	No	Daily Consumption
Smoke			
Drink Alcohol			
Drink Coffee			
Drink Soft Drinks			
Drink Water			

Do You Wear Artificial Devices?	Yes	No
Please List:		
Do You Have Allergies?	Yes	No
Do You Have Allergies To Medications?	Yes	No
Please List:		

MEDICATION LIST

NAME	REASON	DOSE	DATE STARTED

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	Yes	No		Yes	No		Yes	No
Fever			Chest Pain			Urinary frequency		
Weight loss			Palpitations			Painful urination		
Poor appetite			Ankle swelling			Leg cramps		
Fatigue			Cough			Swollen/painful joints		
Blurry vision			Wheezing			Painful legs		
Double vision			Painful breathing			Skin rash		
Eye pain			Nausea / vomiting			Jaundice		
Headache			Constipation			Non-healing skin lesions		
Seizures			Diarrhea			Skin itching		
Numbness			Stomach cramps			Anemia		
Confusion			Urinary urgency			Bruising / abnormal bleeding		