HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____ Age _____ Birth Date _____

Medical Illnesses

1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Surgeries

1	5
2	6
3	7
4	8

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No** If yes, give approximate dates

Medications (including herbal remedies)

1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Medication Allergies & Reaction

1
2
3
4
5

Health Habits

Check which substances you use and describe how much you use		
	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	

Family History

	Cancer	
	Diabetes	
	Heart Disease	
	High Blood Pressure	
	Tuberculosis	
	Strokes	
	Lung Disease	

Occupational Concerns

	Stress	
	Hazardous Substances	
	Heavy Lifting	
	Other	

Your Occupation