FAMILY AND PERSONAL HEALTH HISTORY

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

Check all items either yes or no and give approximate date if past	NO	YES NOW	YES PAST	IF PAST DATE
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (Type)				
Arthritis				
Blindness Either Eye				
Broken Bones				
Cataracts				
Chronic Bronchitis				
Chronic Lung Disease				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Deafness				
Dysentary				
Diabetes				
Epilepsy				
Emphysema				
Enlarged Heart				
Glaucoma				
Gall Stones				
Gout				
Goiter				
Hay Fever				
Heart Murmur				
Heart Attack				
High Blood Pressure				
Hepatitis				
Hemorrhoids				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Polio				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach/Duodenal Cancer				

Check all items either yes or no and give approximate date if past	NO	YES NOW	YES PAST	IF PAST DATE
Skin Disease				
Serious Depression				
Serious Emotional Problems				
Tuberculosis				
Thyroid (overactive)				
Thyroid (underactive)				
Varicose Veins				
Men				
Prostate Problems				
Women				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease*				
Gynecological Problems*				
Still Menstruating				

Age Menstruation Stopped _____
Number of Pregnancies _____
Number of Miscarriages _____
Number of Children _____

*Explain: _____

Hospitilizations/Reason: _____ Date: _____

Do you wear artificial devices? _____
Please List:

Do you have allergies? _____
Please List: _____

Comments: