

Health History Form

The following is information concerning medical history, including allergies, medications being taken, and physical impairments, to which a physician should be alerted:

GENERAL INFORMATION

_____ () Male () Female
(LAST NAME) (FIRST) (MIDDLE) (BIRTH DATE)

PERMANENT MAILING ADDRESS:

(STREET) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

HEALTH PROBLEMS – List any continuing health problems: _____

DRUG ALLERGIES AND REACTION – List any drug allergies and briefly describe what happened:

MEDICINES – List any medicines, pills or injections (prescription and over-the-counter) you take regularly:

HISTORY – Check if you have ever had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart problems (describe)
<input type="checkbox"/> Asthma/hay fever/allergy	<input type="checkbox"/> Jaundice/hepatitis
<input type="checkbox"/> Back problems	<input type="checkbox"/> Protein/sugar in urine
<input type="checkbox"/> Bladder/kidney problem	<input type="checkbox"/> Surgery _____ (TYPE AND YEAR)
<input type="checkbox"/> Epilepsy/convulsions	<input type="checkbox"/> Emotional/mental problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Drug/alcohol problems
<input type="checkbox"/> Ulcer/stomach problem	

Have you ever lived in close contact with anyone who had tuberculosis?

TB skin test: negative _____ year TB Medicines Taken: _____
 positive _____ year
 never tested

Anything else that we should be aware of? _____

FAMILY MEDICAL HISTORY

Has anyone in your family had any of the following problems?

<input type="checkbox"/> Asthma/hay fever	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sickle cell/anemias
<input type="checkbox"/> Heart disease	