Health History Form

Have you or an immediate member (mother, father, sister, brother or grandparent) ever had any of the following conditions?

Check and detail positive findings including date and place of treatment.
Precede findings by reference number.

	Patient	Family
1. Congenital anomalies…….	_____	_____
2. Genetic diseases…….	_____	_____
3. Multiple births……...	_____	_____
4. Diabetes mellitus……	_____	_____
5. Malignancies……	_____	_____
6. Ovarian cancer……	_____	_____
7. Breast cancer……	_____	_____
8. Hypertension (high blood pressure)….	_____	_____
9. Heart attack……	_____	_____
10. Stroke…….	_____	_____
11. Rheumatic fever…….	_____	
12. Pulmonary disease (lung)…….	_____	_____
13. GI problems……	_____	
14. Renal disease (kidney) ……..	_____	_____
15. Genitourinary tract problems…….	_____	
16. Abnormal uterine bleeding……	_____	
17. Infertility……	_____	
18. Venereal disease (STD)…….	_____	_____
19. Blood clots – leg or lung……	_____	_____
20. Phlebitis varicosities……..	_____	
21. Emotional / psychological disorders…	_____	
22. Neurologic disorder…….	_____	_____
23. Headaches / migraines……	_____	
24. Metabolic / endocrine disorders…….	_____	_____
25. Anemia / hemoglobinopathy…….	_____	_____
26. Blood disorders…….	_____	_____
27. Infectious diseases…….	_____	
28. Skin problems……	_____	
29. Operations / accidents……	_____	
30. Allergies / meds sensitivity……	_____	
31. Blood transfusions…….	_____	
32. Other hospitalizations……	_____	
33. Thyroid disease…….	_____	_____
34. Arthritis…….	_____	_____
35. N**o know diseases / problems**		

Do you drink alcohol? _____ If so, how many drinks per week? _____
Do you use recreational drugs? _____ If so, what do you use? _____
How much? _____ How often? _____
Would you like to quit? _____
Do you smoke? _____ How many per day? _____Would you like to quit? _____
Name: _____