GENERAL HEALTH HISTORY

Patient's name: _____ Date _____
Primary care physician: _____
Height: _____Weight: _____Last Blood Pressure: _____

CURRENT PROBLEMS: Do you have any of the following problems?

yes	no		yes	no	
☐	☐	allergies	☐	☐	prostate
☐	☐	arthritis – osteo / rheumatoid	☐	☐	urinary / genital
☐	☐	HIV / AIDS	☐	☐	anemia
☐	☐	elevated cholesterol	☐	☐	fibromyalgia
☐	☐	high blood pressure ____/____	☐	☐	joint / muscle pain
☐	☐	angina	☐	☐	osteoporosis
☐	☐	irregular heart beat	☐	☐	MS
☐	☐	other heart disease _____	☐	☐	stroke
☐	☐	blood disorders _____	☐	☐	depression
☐	☐	kidney	☐	☐	psychiatric illness _____
☐	☐	headache	☐	☐	asthma / emphysema
☐	☐	migraine headache	☐	☐	other lung disease _____
☐	☐	sinus	☐	☐	cancer _____
☐	☐	ears / mouth / nose / throat	☐	☐	shingles
☐	☐	diabetes since:_____	☐	☐	skin _____
☐	☐	thyroid	☐	☐	reaction to anaesthetics
☐	☐	stomach / intestinal			
☐	☐	hysterectomy			
☐	☐	sexually transmitted infection _____			

MEDICATIONS: Please bring list all of the medications, including aspirin, vitamins and herbal supplements that you currently take ***with their dosages***._____
_____
_____

ALLERGIES: Please list all allergies ***to medications*** that you have ☐ NONE
_____

ILLNESSES/ INJURIES: Please list all ***past*** major illnesses (such as cancer) or injuries you have had. ☐ NONE
_____
_____

SURGERIES: Please list all ***past*** surgeries (except eye surgeries) that you have had. ☐NONE
_____
_____

FAMILY HISTORY: Please list medical conditions that affect your ***parents, siblings or children*** including diabetes, thyroid, cholesterol and high blood pressure.
_____
_____