HEALTH HISTORY FORM

Name :

Date of Birth :

Medical History

Question	Response	Date first noted (approx)	Comments
Allergies	Yes No		
COPD/chronic bronchitis	Yes No		
Lung cancer	Yes No		
Anemia	Yes No		
Dementia	Yes No		
Migraines	Yes No		
Anxiety	Yes No		
Depression	Yes No		
Myocardial infraction	Yes No		
Arthritis	Yes No		
Diabetes mellitus	Yes No		
Neve/muscle disease	Yes No		
Asthma	Yes No		
Eye Disease	Yes No		
Brittle bones	Yes No		
Autoimmune Disease	Yes No		
Acid reflux	Yes No		
Prostate cancer	Yes No		
Bipolar disorder	Yes No		
Glaucoma	Yes No		
Seizures	Yes No		
Breast cancer	Yes No		
Gout	Yes No		
Skin cancer	Yes No		
Cancer	Yes No		
Heart murmur	Yes No		
Sleep apnea	Yes No		
Cardiovascular other	Yes No		
Stroke/CVA	Yes No		
Subtance abuse	Yes No		
Leukemia	Yes No		