Health History

Name: _____ DOB:____/____/____ Date:____/____/_____

	You		Family		If yes, who:
Cardiovascular Disease	Yes___	No___	Yes___	No___	_____
High Blood Pressure	Yes___	No___	Yes___	No___	_____
Diabetes Type 1/Type 2	Yes___	No___	Yes___	No___	_____
Stroke	Yes___	No___	Yes___	No___	_____
Heart Attack	Yes___	No___	Yes___	No___	_____
Asthma	Yes___	No___	Yes___	No___	_____
COPD	Yes___	No___	Yes___	No___	_____
Cancer	Yes___	No___	Yes___	No___	_____
	Type_____				**Type**_____
High Cholesterol	Yes___	No___	Yes___	No___	_____
Thyroid Disease	Yes___	No___	Yes___	No___	_____
Heart murmur	Yes____	No___	Yes___	No___	_____
Arthritis	Yes____	No___	Yes____	No____	_____
Autoimmune	Yes____	No____	Yes____	No____	_____
	Type_____				**Type**_____
HIV	Yes____	No____	Yes____	No____	_____
HEP C	Yes____	No____	Yes____	No____	_____
Depression	Yes____	No____	Yes____	No_____	_____
Anxiety	Yes____	No____	Yes____	No_____	_____
Bipolar	Yes____	No____	Yes____	No_____	_____
Schizophrenia	Yes____	No____	Yes____	No_____	_____
PTSD	Yes____	No____	Yes____	No_____	_____
Alcoholism	Yes____	No____	Yes____	No_____	_____
Drug Dependence/Abuse	Yes____	No____	Yes____	No_____	_____

Other:

_____

Past Hospitalizations
(date, location, diagnosis)

_____
_____
_____
_____

Past Surgeries
(date and surgery)

_____
_____
_____
_____