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 infarction	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Diabetes mellitus	☐ Yes ☐ No		
Nerve/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		