
 Doctor

 Address

 Address

 Phone

ADULT HEALTH HISTORY

Date _____

Name _____
 Date of birth _____ Age _____
 General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/sinus	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	
<input type="checkbox"/>	<input type="checkbox"/>	Gastro-intestinal problems	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Learning disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	
<input type="checkbox"/>	<input type="checkbox"/>	Musculo-skeletal	
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/psychiatric	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Serious injury	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies

Signature _____