HEALTH HISTORY

NAME : _____ DATE: _____ Date of Last Physical: _____

Do you have a History of any of the problems listed below? Check all that apply and explain below:

__Anemia/bleeding trait
__Breast disorder/Problems
__High Cholesterol
__Heart Disease
__Severe Anxiety
__Testicular Lump
__PCOS
__Thyroid DZ
__Asthma
__Cancer
__Arthritis
__Indigestion
__Depression
__Weight Loss
__Irreg. Periods
__Kidney DZ
__Allergies(i.e. seasonal, food)
__Chest pain with exercise
__Diabetes/Pre DM
__Irritable Bowels
__Substance Abuse
__Weight Gain
__Medullary Thyroid CA
__Multiple Endocrine Neoplasia Type 2
__ Back or Joint Injuries
__ Chest pain with rest
__ Eating Disorder.
__ Dizziness
__ Shortness of Breath
__ Other _____

Please Explain: _____

_____

HOSPITALIZATION: *Please include all Surgeries, childbirth, (if any)*

YEAR	Reason/Outcome

HABITS: (√) which substance(s) you use and *describe how much you use.*

	Caffeine	
	Tobacco	
	Drugs	
	Stress	
	Other	

Medication(*List ALL medications you are currently using)*	**ALLERGIES** (*List medication or substance)*

Family history (*Fill in health information about your family*)

Relation	Age	State of health/Current health Problems	Age of Death	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				

I request that the medication (s) dispensed be packaged in non-complying container. I know these containers are NOT "CHILD PROOF".

Signed: _____ Date: _____