

HEALTH HISTORY

Name _____ Date _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship to you: _____

Medicines currently taking _____

Allergies including medicines _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

- _____ ANEMIA
- _____ THYROID PROBLEMS
- _____ MIGRAINE HEADACHES
- _____ BLEEDING DISORDERS
- _____ STROKE
- _____ BLOOD CLOTS
- _____ DIABETES
- _____ EPILEPSY
- _____ PNEUMONIA
- _____ DEPRESSION
- _____ HIGH BLOOD PRESSURE
- _____ ULCCRS
- _____ HEART ATTACK
- _____ ANGINA
- _____ PACEMAKER
- _____ KIDNEY DISEASE
- _____ LIVER DISASE
- _____ KIDNEY STONES
- _____ CATARACTS
- _____ GLAUCOMA
- _____ BACK PROBLEMS

IMMUNIZATION RECORD

- _____ HEPATITIS VACCINE
- _____ FLU VACCINE
- _____ PNEUMOCOCCAL VACCINE
- _____ TETANUS TOXOID VACCINE
- _____ OTHER VACCINES

ARE YOUR IMMUNIZATIONS
CURRENT? YES NO

SURGICAL HISTROY (DATE)

- _____ APPENDECTOMY
- _____ CHOLECYSTECTOMY
- _____ HYSTERECTOMHY
- _____ OTHER _____
- _____
- _____

HAVE YOUR BLOOD RELATIVE HAD ANY OF THE FOLLOWING:

- | | | | |
|---------------------|---------------------|--------------------|---------------------|
| _____ | Relationship to you | _____ | Relationship to you |
| _____ CANCER | _____ | _____ STROKE | _____ |
| _____ DIABETES | _____ | _____ TUBERCULOSIS | _____ |
| _____ HEART DISEASE | _____ | _____ OSTEOPOROSIS | _____ |

Do you have Insurance? Please circle. YES / NO

Name of Insurance Company Name: _____

Policy Number: _____

I CEDRTIFY THE ABOVE INFORMATION IS CORRECT AND TRUE TO MY KNOWLEDGE

SIGNATURE

DATE