

NAME: _____

DATE: _____

PAST HEALTH HISTORY: (Circle those that apply)

Abdominal pain	Bulimia	Fainting	Irritable colon	PMS	Sickle cell anemia
Allergies	Cancer	Hay fever	Kidney disease	Polio	Sinus trouble
Angina	Colitis	Headaches	Kidney stones	Profuse menstrual	Spinal disc disorder
Anorexia	Convulsions	Heart attacks	Liver disease	Prostate disease	Stroke
Aneurysm	Diabetes	Heart disease	Low blood pressure	Rapid heart rate	Thyroid disease
Arthritis	Dislocated joints	High blood press	Lung disease	Rheumatic fever	Tuberculosis
Asthma	Dizziness	HIV/AIDS	Multiple sclerosis	Scoliosis	Ulcer
Blood disorder	Emphysema	Irregular bowel	Osteoporosis	Sexually transmitted disease	Vaginal discharge
Breast soreness	Epilepsy	Irregular menstrual	Painful urination		

EXERCISE HABITS: Regularly Occasionallly Rarely Never

SMOKING: Regularly Occasionallly Rarely Never

ALCOHOL: Regularly Occasionallly Rarely Never

MEDICATION CURRENTLY TAKING: Muscle relaxants Analgesics Anti-inflammatory
Psychotropic Hypertension

PAST ACCIDENTS and SURGERIES: _____

