Health History

Please indicate any history of the following conditions for you and your blood relations below.
Y= you; M= mother; F= father; S= siblings; C= children; G= grandparents;
O= other blood relatives such as aunts, uncles, cousins, etc.

	Y	M	F	S	C	G	O
COPD/emphysema	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Cardiac Pacemaker	☐	☐	☐	☐	☐	☐	☐
Angina	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Low Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Hay Fever/Allergies	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐	☐	☐	☐
AIDS or HIV	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Any other disease or condition	☐	☐	☐	☐	☐	☐	☐

	Y	M	F	S	C	G	O
Hepatitis/ Jaundice	☐	☐	☐	☐	☐	☐	☐
STD	☐	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐	☐
Radiation Therapy	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Joint Replacement	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Indigestion or Ulcers	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐

Type of cancer ______________________________

Details: ______________________________

Surgeries/hospitalizations and dates ______________________________

____

Current medications and dosages ______________________________

____

Current vitamins, herbs and supplements ______________________________

____

Allergies to medications, foods or other substances ______________________________

____

Have you ever used tobacco?________ Current type and amount of use ______________________________

Women: Are you pregnant?__________ Are you on oral or other contraceptives? ____________________

Please indicate any symptoms:

	Date started:	Details:	Continuous	Intermittent
Weight loss			☐	☐
Weight gain			☐	☐
Fever			☐	☐
Fatigue			☐	☐
Fever			☐	☐
Weakness			☐	☐
Chills/Sweats			☐	☐
Excessive thirst			☐	☐
Excessive urination			☐	☐
Changes in vision			☐	☐
Difficulty hearing			☐	☐
Ringing in ears			☐	☐
Teeth/gums problems			☐	☐
Hay fever/allergies			☐	☐
Coughing/wheezing			☐	☐
Sexual concern			☐	☐
Headaches			☐	☐
Dizziness/lightheaded			☐	☐
Numbness			☐	☐
Memory Loss			☐	☐
Loss of coordination			☐	☐
Anxiety /Stress			☐	☐
Hot flashes			☐	☐
Heat intolerance			☐	☐
Cold intolerance			☐	☐
Sensitivity to light			☐	☐
Difficulty breathing			☐	☐
Abdominal pain			☐	☐
Nausea/vomiting			☐	☐
Diarrhea			☐	☐
Constipation			☐	☐
Blood in stool			☐	☐
Breast lump/discharge			☐	☐
Palpitations			☐	☐
Leg pain with exercise			☐	☐
Swollen ankles			☐	☐
Fainting			☐	☐
Chest pain/discomfort			☐	☐

	Date started:	Details:	Continuous	Intermittent
Easily winded			☐	☐
Easy bruising/bleeding			☐	☐
Rash or mole change			☐	☐
Muscle/joint pain			☐	☐
Unexplained lumps			☐	☐
Problems with sleep			☐	☐
Depression/sadness			☐	☐
Night-time urination			☐	☐
Leaking urine			☐	☐
Penile discharge			☐	☐
Vaginal discharge			☐	☐
Unusual vaginal bleeding			☐	☐
Other (please explain)			☐	☐
			☐	☐
			☐	☐

Additional comments: ____

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