

CONFIDENTIAL

HEALTH HISTORY

NAME: _____ DATE: _____

AGE: _____ BIRTHDATE: _____ DATE OF LAST PHYSICAL EXAM _____

PRESENT MEDICATIONS: _____

ALLERGIES: _____

IMMUNIZATIONS (date received)

MALARIA PREVENTATIVE: _____ TETANUS: _____

TYPHOID: _____ HEPATITIS TYPE A: _____

CONDITIONS: check conditions you have or have had in the past.

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Emphysema | | |

Any dietary needs or restrictions: _____

Hospitalizations:
