



Patients Name: _____

Date: _____

HEALTH HISTORY

Medical Physician's Name: _____ Date of last medical visit: _____

Please place a check on the line to indicate if you or a blood relative has had any of the following health conditions.

	You	Family		You	Family		You	Family
Cardiovascular Disease	___	/ ___	Aids	___	/ ___	Anxiety Disorder	___	/ ___
Congestive Heart Disease	___	/ ___	HIV Positive	___	/ ___	Autism	___	/ ___
Elevated Cholesterol	___	/ ___	Lyme Disease	___	/ ___	Bi-Polar Disorder	___	/ ___
Heart Murmur	___	/ ___	Rheumatic Fever	___	/ ___	Dementia	___	/ ___
Heart Palpitations	___	/ ___	Sjogren's Syndrome	___	/ ___	Depression	___	/ ___
High Blood Pressure	___	/ ___	Tuberculosis	___	/ ___	Learning Disability	___	/ ___
Crohn's Disease	___	/ ___	Acne Rosacea	___	/ ___	Schizophrenia	___	/ ___
Diabetes	___	/ ___	Lupus	___	/ ___	Asthma	___	/ ___
Thyroid Disorder	___	/ ___	Ocular Rosacea	___	/ ___	exercise induced	___	/ ___
Acid-Reflex Syndrome	___	/ ___	Raynaud's Disease	___	/ ___	Cancer: Lung	___	/ ___
Alcoholism	___	/ ___	Arthritis	___	/ ___	COPD	___	/ ___
Cancer: Colon	___	/ ___	Muscular Dystrophy	___	/ ___	Emphysema	___	/ ___
Cancer: Liver	___	/ ___	Osteoporosis	___	/ ___	Lung Disease	___	/ ___
Hepatitis	___	/ ___	Scoliosis	___	/ ___	Cataracts	___	/ ___
Kidney Stones	___	/ ___	Bell's Palsy	___	/ ___	Glaucoma	___	/ ___
Prostate Cancer	___	/ ___	Brain Damage	___	/ ___	Macular Deg.	___	/ ___
Uterine Cancer	___	/ ___	Brain Tumor	___	/ ___	Lazy /Turned Eye	___	/ ___
Anemia	___	/ ___	Cerebral Palsy	___	/ ___	Poor Color Vision	___	/ ___
Breast Carcinoma	___	/ ___	Dyslexia	___	/ ___	Retinopathy	___	/ ___
Hodgkins Disease	___	/ ___	Epilepsy	___	/ ___	Eye Surgery	___	/ ___
Leukemia	___	/ ___	Headaches(Migraine)	___	/ ___	Type: _____	Date: _____	
Lymphatic Cancer	___	/ ___	Multiple Sclerosis	___	/ ___			
			Parkinson's Disease	___	/ ___			
			Seizure Disorder	___	/ ___			

Other Health Conditions Not Listed Above:

Tobacco use ___ Yes (___ Cigarette or ___ Smokeless) ___ No
 Are you pregnant? ___ Number of Children ___
 Alcohol use ___ Social ___ 1-2 per Day ___ Above Avg. ___ Dependent ___ None

MEDICATIONS **ALLERGIES**

	/	
	/	
	/	
	/	