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Health Information

A. Identification

Your name: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Table with 5 columns: Age, Illness/diagnosis, Treatment received, Treated by, Result. Includes 5 rows of blank lines for data entry.

2. Describe any allergies you have.

Table with 3 columns: To what?, Reaction you have, Allergy medications you take. Includes 3 rows of blank lines for data entry.

3. List all medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Table with 4 columns: Medication/drug, Dose (how much?), Taken for, Prescribed and supervised by. Includes 4 rows of blank lines for data entry.

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Table with 4 columns: Date, Kinds of chemicals, Kind of work, Effects. Includes 4 rows of blank lines for data entry.

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____

3. Do you try to restrict your eating in any way? How? Why? _____

4. Do you have any problems getting enough sleep? _____

E. For women only

1. At what age did you start to menstruate (get your period): _____

2. Menstrual period experiences:

- a. How regular are they? _____
- b. How long do they last? _____
- c. How much pain do you have? _____
- d. How heavy are your periods? _____
- e. Other experiences during period? _____

3. Please list all of your pregnancies:

	Your age	What happened with this pregnancy?			Problems?
		Miscarriage	Abortion	Child born	
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

4. Menopause:

- a. If your menopause has started, at what age did it start? _____
- b. What signs or symptoms have you had? _____

F. Other

Are there any other medical or physical problems you are concerned about? _____
