

Medical History & Health Questionnaire

Name: Date of Birth:
 Age Sex M F Student Grade:
 Occupation: Hobbies?
 Are you allergic to any medications Yes No

If yes, please list here

List all medications you are taking (including prescriptions, over-the-counter medications, vitamins and herbals):

Do you have now, or have you ever had diseases or conditions of: Please place an X in the correct box. If yes, please explain.

Condition	No	Yes	If Yes, explain:
Anemia			
Arthritis / Joint Deformity / Lupus			
Asthma, Eczema			
Bleed easily			
Cancer, Skin Cancer			
Convulsions / Epilepsy / Seizures			
Diabetes			
Fainting/Dizziness			
Fibromyalgia			
Gastrointestinal Problems			
Heart Trouble			
Hepatitis			
HIV / AIDS Exposure or Disease			
High Blood Pressure			
Kidney / Bladder Problems			
Lung / Breath Problems			
Osteoporosis			
Pacemaker			
Phlebitis / Blood clots			
Problems Healing / excessive scarring			
Psychiatric problems/Depression			
Thyroid Condition			
Yeast infection when taking antibiotic			

Are you on birth control patches, pills, or injections? Yes No

Do you suspect you are currently pregnant or is there a chance of pregnancy?

Family history:

Please "X" any diseases which run in your family

- Diabetes
 Hypertension
 Heart Attacks
 Strokes
 Depression
 Asthma
 High Cholesterol

Social History:

Tobacco Use: Yes No If yes, # of years, and how much?

Alcohol Use: Yes No If yes, type & amount:

Marital Status: