

MY HEALTH HISTORY

<p>Ability & Disability</p> <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Learning Disability <input type="checkbox"/> Mobility/Wheel Chair <input type="checkbox"/> Non-correctable Visual Impairment <p>Blood Disorders</p> <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blood Clots/Phlebitis <p>Bone and Joint Problems</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Pain, chronic <input type="checkbox"/> Lupus <p>Cancer</p> <input type="checkbox"/> Leukemia or Lymphoma <input type="checkbox"/> Melanoma <input type="checkbox"/> Testicular Cancer	<p>Endocrine (gland)</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disorder <p>Eye/Vision</p> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Wear glasses or contacts <p>Gastrointestinal/Stomach</p> <input type="checkbox"/> Inflammatory Bowel Disease <p>Heart/Cardiovascular</p> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Passed out with exercise <input type="checkbox"/> Stroke <p>Infections</p> <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Immunocompromising Illness	<p>Infections - continued</p> <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Sexually Transmitted Infection <input type="checkbox"/> Tuberculosis or Positive Skin Test <input type="checkbox"/> COVID-19 <p>General Health</p> <input type="checkbox"/> Use Tobacco <input type="checkbox"/> Drink Alcohol <input type="checkbox"/> Use recreational drugs <input type="checkbox"/> Use caffeine or energy drinks <p>Mental Health</p> <input type="checkbox"/> Alcoholism/Drug Abuse <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder (Manic/depression) <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder	<p>Neurological (Brain)</p> <input type="checkbox"/> Attention Deficit <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Seizure <p>Respiratory/Breathing</p> <input type="checkbox"/> Asthma (including exercise-induced asthma) <input type="checkbox"/> Cystic Fibrosis <p>Urinary</p> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Urinary Infections (Cystitis) <p>Language</p> <input type="checkbox"/> My primary language (if not English) _____ <p>Height _____ Weight _____</p>
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Explain any items you have checked in the comment section below. Include any additional significant illnesses.

Medication: List all medications you take regularly, including birth control pills, non-prescription drugs and herbal preparations

Name of Medication	Dosage of Medication

Allergies: List any allergic or other significant reactions to medication.

Medication causing Allergy	Type of Reaction	Approximate Date of Onset

Surgery, significant injuries, hospital stays: Describe and include dates.

Description	Approximate Date

Family History: Complete the fields to the best of your knowledge for family members. Include heart disease, high cholesterol, diabetes, high blood pressure, tuberculosis, stroke, alcoholism, depression, other mental illness, and cancer (specify type). **Are you adopted?** Yes No

1. **Father:** Year of Birth: _____ Occupation: _____ Age at Death(if deceased): _____
Cause of Death (if deceased): _____

Medical Problems	Approximate Onset Date	Comment

2. **Mother:** Year of Birth: _____ Occupation: _____ Age at Death(if deceased): _____
Cause of Death (if deceased): _____

Medical Problems	Approximate Onset Date	Comment

3. **Siblings:** 1st Sibling Year of Birth: _____ 2nd Sibling Year of Birth: _____ 3rd sibling Year of Birth: _____
Age at Death(if deceased): _____ Cause of Death (if deceased): _____

Medical Problems	Approximate Onset Date	Comment