Name:________________________________ Blood Type:_______________________

Medical Health History

Medical Health Conditions:

	Self	Family Member
None		
Allergies – Food/Seasonal	O	O
Arthritis	O	O
Asthma	O	O
Cancer	O	O
Diabetes	O	O
Glaucoma	O	O
Heart Condition	O	O
High Blood Pressure	O	O
High Cholesterol	O	O
Thyroid Disease	O	O
Other (please specify)	O	O

Hospitalizations/Surgeries & Dates:

Current Medications:

Medication Allergies:

Name:________________________________ Blood Type:_______________________

Diagnostic Tests Taken & Dates:

History of Presenting Problem:

(Remember to include relevant information, like dates, symptoms, duration, etc)

Pertinent Familial History: