

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness:

- None
- ADD
- Depression
- Measles
- Unusual Childhood Illness
- Allergies/Hayfever
- Diabetes
- Mumps
- Asthma
- Fetal Drug Exposure
- Rash
- Atopic Dermatitis
- Food Allergies
- Seizure Disorder
- Cerebral Palsy
- Headaches
- Sickle Cell Anemia
- Chicken Pox
- Hepatitis
- Spina Bifida

Adult Illness:

- None
- Anemia
- CVA
- Hepatitis
- Seizures
- Arthritis
- Depression
- Hypertension
- Similar Symptoms
- Asthma
- Diabetes (Insulin Dep.)
- Kidney Disease
- STD's
- Cancer
- Diabetes (NIDDM-Noninsulin)
- Liver Disease
- Suicide Attempts
- Chicken Pox
- Eye Problems
- Lung Disease
- Thyroid Problems
- CRPS (RSD)
- Heart Disease
- Psychiatric Problem

Surgeries:

- None
- Angioplasty
- Cosmetic
- Joint Replacement
- Gallbladder
- Appendectomy
- D&C
- Laminectomy
- Caesarean Section
- Hemorrhoidectomy
- Mastectomy
- Cardiac Catheterization
- Hernia Repair
- Pacemaker Insertion
- Carpal Tunnel Repair
- Hysterectomy
- Spinal Fusion
- Coronary Bypass
- Joint Reconstruction
- Tonsillectomy
- Other: _____

Ob/Gyn – Describe: _____

- None

Injuries – Describe: _____

- None

Immunizations:

- | | | |
|-------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Varivax |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> MMR |
| <input type="checkbox"/> PPD | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> TD | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Others |

Non-Drug Allergies-Describe: _____

- None

FAMILY HISTORY

	Alive	Deceased	Condition (of Health or reason for Death)
General Family	___	___	_____
Father	___	___	_____
Mother	___	___	_____
Paternal Grandfather	___	___	_____
Paternal Grandmother	___	___	_____
Maternal Grandfather	___	___	_____
Maternal Grandmother	___	___	_____
Son(s)	___	___	_____
Daughter(s)	___	___	_____
Brother(s)	___	___	_____
Sister(s)	___	___	_____