Health History

Today's date:_____

Last Name **First Name** **Middle Initial** **Date of Birth**

Male or Female

Medications: Please list below the medications you are taking. Include prescription and other medicines such as aspirins, vitamins, cold medicines, health food and herbal preparations, etc.

Name of Medication **Amount** **How Often**

Surgeries
Have you ever had any surgeries? Yes or No
If yes, please describe the operation and Approximate date.

Type of Surgery: Date

Allergies:
Have you ever had an allergic reaction to food medicine, or any other substance? **If Yes** Describe below:

Substance Reaction Year

Life Style and Health Habits

Do you… Year	Yes	No	Please describe
Smoke			
Drink Alcohol			
Drink Caffeine			
Other			
Number of People in household			
Have you any hobbies or interest			
Have you been exposed to hazardous materials			
Exercise regularly			
Sleep during the night			
Take naps during the day			
Eat enough each day			
Wear a seat belt			
Wear sunblock			
Culture/religious issues that may effect medical care			
Occupation			
How many hours a week do you work			