Medical History

Name: _____ **Date:** _____

Height: ____ ft. ____ in. **Weight:** _____ (pounds)

Chronic Illnesses:

_____

_____

Hospitalizations/ER visits in past 12 months:

_____

_____

Previous Surgeries and dates (if known):

_____

_____

Do you have or have had any of the following: Diabetes ☐ Hypertension ☐ Stroke ☐
Heart Disease ☐ Lung Problems ☐ Blood Clots ☐ Seizures ☐ Depression/Anxiety ☐
Cancer ☐ Type: _____

HAS ANY RELATIVE HAD THE FOLLOWING:

Disease	**Which Relative(s)?** (i.e. mother, father, etc…)
☐ Alcoholism	
☐ Alzheimer's Disease	
☐ Anemia/Low Blood Count	
☐ Lung Problems	
☐ Cancer, Breast	
☐ Cancer, Colon	
☐ Cancer, Prostate	
☐ Cancer, Other	
☐ Heart Disease	
☐ Depression	
☐ Bipolar Disorder	
☐ Diabetes	
☐ Blood Clots	
☐ Hearing Loss	
☐ Hypertension	
☐ High Cholesterol	
☐ Osteoporosis	
☐ Stroke	
☐ Other	

SOCIAL HISTORY

EXERCISE: Type: _____ _____ How Often? _____	SMOKING: Packs Per Day ___ No. of years ___ Year Stopped ___ Vape? ___	ALCOHOL: Drinks per day ___ Drinks per week ___ Alcohol problem?	RECREATIONAL DRUGS: ☐Yes ☐No Type: _____