# Health History

Name_______________________________________________Date_____________________

Age____________________Height____________________Weight_______________________

**PLEASE CHECK ANY CONDITIONS YOU HAVE HAD**
**(Place a "C" by those conditions you currently have)**

- ❑ AIDS/HIV
- ❑ ANEURYSM
- ❑ CANCER
- ❑ COLITIS
- ❑ EPILEPSY
- ❑ HEADACHES
- ❑ OSTEOPOROSIS
- ❑ PROSTATE
- ❑ SINUS
- ❑ ULCERS
- ❑ ALCOHOLISM
- ❑ ARTHRITIS
- ❑ CATARACTS
- ❑ CONSTIPATION
- ❑ GLAUCOMA
- ❑ HEPATITIS
- ❑ HIGH CHOLESTEROL
- ❑ POLIO
- ❑ STROKE
- ❑ VENEREAL DISEASE
- ❑ ALLERGIES
- ❑ ASTHMA
- ❑ DRUG DEPENDENCY
- ❑ DEPRESSION
- ❑ GOUT
- ❑ HERNIA
- ❑ RHEUMATIC FEVER
- ❑ THYROID DISORDER
- ❑ SHINGLES
- ❑ ANEMIA
- ❑ BACK PAIN
- ❑ NECK PAIN
- ❑ DIABETES
- ❑ HEART DISEASE
- ❑ HERNIATED DISC
- ❑ MONONUCLEOSIS
- ❑ RHEUMATOID ARTH.
- ❑ TUMORS
- ❑ OTHER____________

Medications you currently take ____________________________________________________

Supplements you currently take_____________________________________________________

Accident/ falls/ broken bones_______________________________________________________

Surgeries/year_____________________________________________________________

Hospitalizations other than above____________________________________________________

___________________________________________________________________________

What conditions have you been treated for in the past year___________________________________
Treating doctors_____________________________________________________________

| Family History | Diabetes | Heart | Kidney | Cancer | Headaches |
|---|---|---|---|---|---|
| Mother | | | | | |
| Father | | | | | |
| Siblings | | | | | |

| Daily Habit | Caffeine | Alcohol | Sugar | Exercise | Sleep | Tobacco |
|---|---|---|---|---|---|---|
| Excessive | | | | | | |
| Moderate | | | | | | |
| Occasional | | | | | | |
| Never | | | | | | |

Sleeping Habits
Mattress Type_________________________________________
Pillow Type___________________________________________
Typical Sleeping Position________________________________

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