MEDICAL HEALTH / FAMILY HEALTH HISTORY FORM

Name: _____ Date of Birth: _____

INSURANCE INFORMATION

Name of Company: _____

Member ID: _____ Group Number: _____

PRIMARY HEALTH CARE PROVIDER

Name of Doctor: _____ Phone Number: _____

Address: _____

PERSONAL HEALTH HISTORY

- ☐ Acid Reflux
- ☐ Alcohol Addiction
- ☐ Allergy Problems
- ☐ Anemia
- ☐ Anxiety
- ☐ Artery / Vein Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bipolar Disorder
- ☐ Bladder Irritability
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis / Crohns
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Esophagitis, ulcers
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Valve Problems
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent Skin Infections
- ☐ Recurrent UTI
- ☐ PTSD
- ☐ Seizures
- ☐ STD's
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid Diseases
- ☐ Vision Impairment

Other Medical Issues: _____

_____

_____

Hospitalizations / Significant Injuries: _____

_____

_____

Surgeries / Procedures: _____

_____

_____

FAMILY HEALTH HISTORY FORM

- [ ] Acid Reflux _____
- [ ] Alcohol Addiction _____
- [ ] Allergy Problems _____
- [ ] Anemia _____
- [ ] Anxiety _____
- [ ] Artery / Vein Problems _____
- [ ] Arthritis _____
- [ ] Asthma _____
- [ ] Autoimmune Disease _____
- [ ] Bipolar Disorder _____
- [ ] Bladder Irritability _____
- [ ] Bleeding Problems _____
- [ ] Blood Clots _____
- [ ] Cancer _____
- [ ] Cataracts _____
- [ ] Colitis / Crohns _____
- [ ] Chronic Pain _____
- [ ] Depression _____
- [ ] Diabetes _____
- [ ] Drug Addiction _____
- [ ] Esophagitis, ulcers _____
- [ ] Fractures _____
- [ ] Gallstones _____
- [ ] Glaucoma _____
- [ ] Gout _____
- [ ] Headaches _____
- [ ] Hearing Impairment _____
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- [ ] Heart Disease _____
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- [ ] Kidney Disease _____
- [ ] Kidney Stones _____
- [ ] Liver Disease _____
- [ ] Lung Disease _____
- [ ] Mental Illness _____
- [ ] Migraines _____
- [ ] MRSA _____
- [ ] Osteoporosis _____
- [ ] Recurrent Skin Infections _____
- [ ] Recurrent UTI _____
- [ ] PTSD _____
- [ ] Seizures _____
- [ ] STD's _____
- [ ] Sleep Apnea _____
- [ ] Stroke _____
- [ ] TB _____
- [ ] Thyroid Diseases _____
- [ ] Vision Impairment _____

Other Medical History: _____