

Name: _____ Date: _____ Location: _____

Check each item. Yes No

Check each item.	Yes	No
Measles		
Mumps		
Chicken pox		
Mononucleosis		
Rheumatic fever		
Headaches		
Head injury		
Seizures		
Fainting		
Skin/mole changes		
Skin cancer		
Rashes		
Open sores		
Deafness		
Ringing in ears		
Ear infection		
Ear tubes		
Glaucoma		
Eye surgery		
Glasses/contacts		
Cataracts		
Mouth cancer		
Dentures		
Overweight		
Underweight		
Thyroid surgery		

Yes No

	Yes	No
Underactive thyroid		
Extreme fatigue		
Depression		
Anxiety attacks		
Blood clot		
Easy bruising		
Anemia		
High cholesterol		
Tuberculosis		
Pneumonia		
Bronchitis		
Asthma		
Shortness of breath		
Emphysema		
Chest pain		
Heart catheterization		
Open heart surgery		
Heart attack		
Heart failure		
High blood pressure		
Swelling in limbs		
Leg cramps		
Ulcers		
Constipation		
Diverticulitis		
Heartburn		

Yes No

	Yes	No
Diarrhea		
Liver disease		
Kidney infection		
Unable to hold urine		
Kidney stones		
Urinate a lot at night		
Kidney failure		
Hemodialysis		
Rheumatoid arthritis		
Gout		
Broken bones		
Osteoarthritis		
Diabetes		
Immunity problems		
Hysterectomy		
Female cancer		
Abortion		
Positive Pap smear		
Infertility		
Prostatitis		
Impotence		
Infertility		
Blood transfusion		
Organ transplant		
Sexually transmitted disease		

FEMALES

MALES

Name: _____ Date: _____ Location: _____

SURGERY - Please list surgery and date

MEDICATIONS - Please list all current medications

ALLERGIES

FAMILY HISTORY

Yes No

Who?

	Yes	No	Who?
High blood pressure			
Diabetes			
Heart disease			
Kidney disease			
Liver disease			
Depression			
Alcoholism			
Suicide			
Cancer			
Other:			