

# Confidential Health Form

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Day / Month/ Year

Permanent Address \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_ (\_\_\_\_) \_\_\_\_\_ Work Phone \_\_\_\_ (\_\_\_\_) \_\_\_\_\_

1. Blood Type \_\_\_\_\_ 2. Height \_\_\_\_\_ 3. Weight \_\_\_\_\_ (in pounds please)

4. Rate your health: Very Good Good Average Below Average Other

5. Explain any recent weight changes \_\_\_\_\_

6. List all important past surgeries, X rays, illnesses, injuries, or handicaps ( please explain ): \_\_\_\_\_

7. Please describe any special dietary needs: \_\_\_\_\_ 8. Does this limit you in any way? \_\_\_\_\_

9. Date of last medical exam: \_\_\_\_\_  
Day / Month/ Year

10. Do you drink alcoholic beverages?  Yes  No If yes, how often? \_\_\_\_\_ how much? \_\_\_\_\_

11. Do you smoke?  Yes  No Are you willing to quit?  Yes  No

12. Are you presently taking any medication?  Yes  No If "yes", name the drug \_\_\_\_\_ What for? \_\_\_\_\_

13. Have you ever had a severe emotional upset, or been diagnosed with a mental illness (i.e. depression or other mental illness)?  
If "yes", please describe.

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14. Have you ever used drugs for anything other than medical purposes? If "yes" when? \_\_\_\_\_

Name of drug(s) \_\_\_\_\_ For how long? \_\_\_\_\_

15. Are you pregnant ? Yes No If "yes" what is your due date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Have you ever had or do you have any of the following? If "yes" please describe on a separate piece of paper.

- |                    |  |                        |  |                      |  |
|--------------------|--|------------------------|--|----------------------|--|
| Skin condition     | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recurrent diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type? _____          |  |
| Intestinal Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Allergy to:</i>     |  | Ear trouble          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head injury        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye trouble          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Migraines          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfonamides           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Serum                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting spells    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Food - specify _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nervous disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other-specify _____    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Weakness           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism/Arthritis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor/Cancer         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Conditions       | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |
| Paralysis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |
| Insomnia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dislocation of joints  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Females Only:</i> |  |
| Jaundice           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Broken bones           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular periods    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/duodenal ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe cramps        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gall bladder problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive flow       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever had any of the following communicable diseases?

- |              |  |                       |  |                   |  |
|--------------|--|-----------------------|--|-------------------|--|
| Chicken Pox  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles (Rubella)     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles (Rubeola) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pertussis             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (specify) _____ |  |                   |  |

**Immunization Record**

Date ( Month/ Year)

- DPT./Td (Series of 3)    Yes   No
- Td Booster                Yes   No
- Tetanus Booster        Yes   No
- Polio (Series of 3)     Yes   No
- Polio Booster           Yes   No
- Measles                  Yes   No
- Rubella                   Yes   No
- Typhoid (Series of 3)   Yes   No
- Cholera                   Yes   No
- Smallpox                 Yes   No
- Yellow Fever            Yes   No
- BCG                        Yes   No

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Have any of your relatives ever had any of the following?

Relationship

- Tuberculosis            Yes   No
- Diabetes                 Yes   No
- Kidney Disease        Yes   No
- Heart Disease          Yes   No
- Arthritis                Yes   No
- Stomach Disease       Yes   No
- Asthma, Hay Fever     Yes   No
- Epilepsy                Yes   No

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