

# Health History

Client Name:	Age:
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## Current Primary Care Provider

Check if none

Name	Date of last appointment: (mo/yr)

## Current Medications

Check if none

Medication Name/ Dosage	Prescriber:

Medication Name/ Dosage	Prescriber:

Medication Allergies: \_\_\_\_\_  Check if none

Other Allergies (e.g. food, latex, bee sting): \_\_\_\_\_  Check if none

## Previous Surgeries or Procedures

Check if none

Name or Procedures	Mo/Yr

Name or Procedures	Mo/Yr

### All Clients:

Do you have a dentist?  Yes  No

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### Clients twelve and under:

Are immunizations current?  Yes  No

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### Female Clients:

Are you pregnant?  Yes  No

If yes, have you obtained prenatal care?  Yes  No

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Do you have?	Please Describe:	Have you discussed with your doctor or health care provider?
Bleeding or bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or discomfort	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with binge eating or purging ( <i>purposeful vomiting</i> )?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special diet for medical reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
TB/Exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained weight loss or weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other health conditions or concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_