## MY HEALTH HISTORY

### Ability & Disability
- Hearing Impaired
- Learning Disability
- Mobility/Wheel Chair
- Non-correctable Visual Impairment

### Blood Disorders
- Bleeding Disorder
- Blood Clot/Phlebitis

### Bone and Joint Problems
- Arthritis
- Back Pain, chronic
- Lupus

### Cancer
- Leukemia or Lymphoma
- Melanoma
- Testicular Cancer

### Endocrine (gland)
- Diabetes
- Thyroid Disorder

### Eye/Vision
- Glaucoma
- Wear glasses or contacts

### Gastrointestinal/Stomach
- Inflammatory Bowel Disease

### Heart/Cardiovascular
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- Passed out with exercise
- Stroke

### Infections
- Hepatitis B or C
- Immunocompromising Illness

### Infected - continued
- Sexually Transmitted Infection
- Tuberculosis or Positive Skin Test

### General Health
- Use Tobacco
- Use recreational drugs
- Use caffeine or energy drinks

### Mental Health
- Alcoholism/Drug Abuse
- Bipolar Disorder
  (Manic/depression)
- Depression
- Eating Disorder

### Neurological (Brain)
- Attention Deficit
- Migraine Headaches
- Seizure

### Respiratory/Breathing
- Asthma (including exercise-induced asthma)
- Cystic Fibrosis

### Urinary
- Kidney Stones
- Polycystic Kidney Disease
- Urinary Infections (Cystitis)

### Language
- My primary language (if not English)

### Height
- Weight

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### Medication
- List all medications you take regularly, including birth control pills, non-prescription drugs and herbal preparations.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage of Medication</th>
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<tbody>
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</tbody>
</table>

### Allergies
- List any allergic or other significant reactions to medication.

<table>
<thead>
<tr>
<th>Medication causing Allergy</th>
<th>Type of Reaction</th>
<th>Approximate Date of Onset</th>
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<tbody>
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</tbody>
</table>

### Surgery, significant injuries, hospital stays
- Describe and include dates.

<table>
<thead>
<tr>
<th>Description</th>
<th>Approximate Date</th>
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### Family History
- Complete the fields to the best of your knowledge for family members. Include heart disease, high cholesterol, diabetes, high blood pressure, tuberculosis, stroke, alcoholism, depression, other mental illness, and cancer (specify type).  Are you adopted? □ Yes □ No

1. Father: Year of Birth: __________  Occupation: __________________  Age at Death(if deceased): _______
   - Medical Problems  Approximate Onset Date  Comment
   |                          |                        |                          |
   |                          |                        |                          |

2. Mother: Year of Birth: __________  Occupation: __________________  Age at Death(if deceased): _______
   - Medical Problems  Approximate Onset Date  Comment
   |                          |                        |                          |
   |                          |                        |                          |

3. Siblings: 1st Sibling Year of Birth: __________  2nd Sibling Year of Birth: __________  3rd sibling Year of Birth: __________
   - Age at Death(if deceased): _______  Cause of Death (if deceased): __________
   - Medical Problems  Approximate Onset Date  Comment
   |                          |                        |                          |
   |                          |                        |                          |

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