

Patient Name: _____

Panhandle Health District

Date of Birth: _____

Health History

PAST MEDICAL HISTORY

		<u>ONSET DATE</u>			<u>ONSET DATE</u>
<input type="checkbox"/>	Allergies		<input type="checkbox"/>	Heartburn	
<input type="checkbox"/>	Anemia		<input type="checkbox"/>	Headache, Migraine	
<input type="checkbox"/>	Chest Pain		<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	Anxiety		<input type="checkbox"/>	Heart Valve Disorder	
<input type="checkbox"/>	Arthritis		<input type="checkbox"/>	Hepatitis / Liver Disease	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	Atrial Fibrillation		<input type="checkbox"/>	Irritable Bowel Disease	
<input type="checkbox"/>	Blood Clots		<input type="checkbox"/>	Lupus	
<input type="checkbox"/>	Cancer		<input type="checkbox"/>	Heart Attack	
	Type: _____		<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	Irregular Heart Beat		<input type="checkbox"/>	Kidney Problems	
<input type="checkbox"/>	Lung Disease		<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Coronary Artery Disease		<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	Depression		<input type="checkbox"/>	Thyroid Problem	
<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	Other:	
<input type="checkbox"/>	High Cholesterol			_____	
<input type="checkbox"/>	Gallbladder Disease				

PAST SURGICAL HISTORY

		<u>DATE</u>			<u>DATE</u>
<input type="checkbox"/>	Artery Procedure		<input type="checkbox"/>	D&C (Dilation and Curettage)	
<input type="checkbox"/>	Appendix Removal		<input type="checkbox"/>	Gastric Bypass Type: _____	
<input type="checkbox"/>	Joint Surgery		<input type="checkbox"/>	Hernia Repair	
<input type="checkbox"/>	Back Surgery		<input type="checkbox"/>	Hip Replacement	
<input type="checkbox"/>	Tubes Tied		<input type="checkbox"/>	Uterus Removed	
<input type="checkbox"/>	Blood Transfusion		<input type="checkbox"/>	Knee Replacement	
<input type="checkbox"/>	Breast Surgery		<input type="checkbox"/>	Eye Surgery (LASIK)	
<input type="checkbox"/>	Heart Surgery		<input type="checkbox"/>	Breast Removal	
<input type="checkbox"/>	Pacemaker		<input type="checkbox"/>	Uterine Surgery	
<input type="checkbox"/>	Carpal Tunnel Release		<input type="checkbox"/>	Bone Fracture Repair	
<input type="checkbox"/>	Cataract Surgery		<input type="checkbox"/>	Thyroid Removed	
<input type="checkbox"/>	Gallbladder Removed		<input type="checkbox"/>	Tonsils Removed	
<input type="checkbox"/>	Colon Surgery		<input type="checkbox"/>	OTHER:	

FAMILY HEALTH HISTORY (FOR PARENTS, BROTHER, OR SISTER ONLY)

<input type="checkbox"/>	ADD / ADHD	Family Member	_____	<input type="checkbox"/>	Hearing Deficiency	Family Member	_____
<input type="checkbox"/>	Alcoholism	Family Member	_____	<input type="checkbox"/>	High Blood Pressure	Family Member	_____
<input type="checkbox"/>	Alzheimer's Disease:	Family Member	_____	<input type="checkbox"/>	Irritable Bowel Disease	Family Member	_____
<input type="checkbox"/>	Arthritis	Family Member	_____	<input type="checkbox"/>	Learning Disability	Family Member	_____
<input type="checkbox"/>	Asthma	Family Member	_____	<input type="checkbox"/>	Mental Illness	Family Member	_____
<input type="checkbox"/>	Blood Disorder	Family Member	_____	<input type="checkbox"/>	Migraines	Family Member	_____
<input type="checkbox"/>	Cancer	Family Member	_____	<input type="checkbox"/>	Obesity	Family Member	_____
<input type="checkbox"/>	Heart Disease	Family Member	_____	<input type="checkbox"/>	Osteoporosis	Family Member	_____
<input type="checkbox"/>	Heart Attack	Family Member	_____	<input type="checkbox"/>	Peripheral Vascular Disease	Family Member	_____
<input type="checkbox"/>	Depression	Family Member	_____	<input type="checkbox"/>	Kidney Problem	Family Member	_____
<input type="checkbox"/>	Developmental Delay	Family Member	_____	<input type="checkbox"/>	Seizures	Family Member	_____
<input type="checkbox"/>	Diabetes	Family Member	_____	<input type="checkbox"/>	Stroke	Family Member	_____
<input type="checkbox"/>	Eczema	Family Member	_____	<input type="checkbox"/>	Thyroid Problem	Family Member	_____
<input type="checkbox"/>	High Cholesterol	Family Member	_____	<input type="checkbox"/>	OTHER:	Family Member	_____
<input type="checkbox"/>	Genetic Disease	Family Member	_____				