Health and Personal History

Name:

DOB:

Date:

What allergies to Medication do you have?

Do you have any other allergies (for example, food allergies?)

Medical Conditions:

Check any that apply and explain in margin

- ☐ Neurological Disorders
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Stroke
- ☐ Loss of Consciousness

- ☐ Vision Disorders
- ☐ Hearing Disorders

- ☐ Respiratory Disorders
- ☐ Asthma
- ☐ Emphysema

- ☐ Cardiac Disorders

- ☐ Liver Disorders

- ☐ Kidney Disorders

- ☐ Skin Disorders

- ☐ Bone or Muscle Disorders

- ☐ Blood Disorders or Cancer

- ☐ Other: (please specify)

Please list your current medications:
(Use back if needed)

Please list any surgeries or previous hospitalizations:
(Use the back of this form if necessary)

Do you use alcohol? Yes / No

Do you use chemical substances/ illegal drugs? Yes / No
If so, how much?