



## PERSONAL HISTORY

Please answer all questions about your health. Please comment on “yes” answers on a separate sheet of paper.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

DO YOU HAVE?	YES	NO	DO YOU HAVE?	YES	NO	DO YOU HAVE?	YES	NO
Fainting			Chronic Cough			Allergies:		
Recurring Headaches			Pain/Pressure in Chest			Name Them		
Seizure Disorder			Heart Disease			Foods		
Convulsions			High Blood Pressure			Drugs		
Head Injury with Unconsciousness			Diabetes			Others		
Eye Disease or Color Blindness			Hypoglycemia			Disease or injury of Joints		
			Menstrual Problems			Chemical Dependency:		
Shortness of Breath			Anorexia/Bulimia			Alcohol		
Asthma			Blackout Problems			Recurrent Anxiety		
Tuberculosis			Depression			Chicken Pox		
						Insomnia		

## FAMILY HISTORY

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

## OTHER IMPORTANT QUESTIONS

Please comment on all “yes” answers. Your answers, as always, will remain confidential.

1. Have you had any serious injury, or been hospitalized for medical, surgical, or psychiatric reasons within the past five years? (If yes, please give reason(s) and duration.)
2. Is your physical activity currently restricted, or has it been restricted in the past five years? (If yes, please give reason and duration.)
3. Are you currently on any medication? (Specify names and dosages below.)
  - a. Prescription:
  - b. Over-the-counter:

Yes	No