Health Inventory Form

(This information is confidential and will only be released with your signed consent)

Name: Date of birth:

Address:

Phone number:

E-mail address:

Emergency contact: Name:

Phone #: Relationship:

If under 18 please provide parents' name, phone number & address

Referred by:

Family Physician: Name & address:

Family History

☐ Check if family history is unknown.

Relationship	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problem

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

Problem Relationship

Alcohol/drug problem
Allergy/ Asthma
Anemia
Arteriosclerosis
Cancer
Diabetes
Epilepsy/seizure
Hear disease
Skin disease

High Blood Pressure
High Cholesterol
Mental illness
Suicide
Thyroid disease
Tuberculosis
Syphilis
Gonorrhea

Personal History

Allergies

I am allergic to following medications and/or foods

____

____

Surgery

List all the surgeries and approximate dates

____

____

Other hospitalizations and dates

____

____

Broken Bones and/or treatment injuries

____

____

Life Style

I am now or have been a smoker: Yes ☐ No ☐
How many years have you smoked? ____

When did you quit?

I use beer ☐ wine ☐ hard liquor ☐

I consider myself a:

Heavy drinker ☐ Social drinker ☐ Non-drinker ☐ Alcoholic ☐ Recovering alcoholic ☐

I have been victim of abuse:
Physical ☐ Sexual ☐ Emotional ☐

My last physical exam was: ____

Current medications

Please list all prescribed and non-prescribed, vitamin & supplements including dosage

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