

HEALTH HISTORY
(information to be furnished by applicant)

NAME: _____ **DATE OF BIRTH:** _____

Family history:

	Living		Deceased		
	Age	Health	Age at Death	Date	Cause of Death
Father					
Mother					
Brothers					
Sisters					
Spouse/ Partner					
Children					

Is there a family history of the following:

	Yes	No	If yes, clarify
Abuse			
Alcoholism			
Alzheimer's Disease/Dementia			
Cancer			
Coronary Artery Disease			
Depression			
Diabetes			
Gastro-intestinal problems			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Mental Illness			
Post-traumatic stress disorder			
Trauma			

Personal information:

Height _____ Weight _____ Glasses/contacts? _____ Hearing _____

How would you describe your physical, emotional, and spiritual health?

Surgeries and hospitalizations for physical or mental health, type and date:

Serious illnesses, nature and date:

Serious injuries, nature and date:

Any physical accessibility concerns?

Have you consulted a physician in the past five years? If so, and for what reason?

When was your most recent physical exam? What were the results?

Have you consulted a psychiatrist or other mental health professional in the past 5 years? If so, when and for what reason?

Personal information, continued...

Do you have any allergies? Drug sensitivities? Special needs?

If you are taking medications regularly (both prescription and over-the-counter drugs), please give their names, dosage and reasons.

Do you have a regular meditation or prayer practice? If so, what?

Do you follow a physical fitness program? If so, what exercise, recreation, sports, etc.?

Do you have any of the following symptoms regularly or severely enough to cause you concern?

	Yes	No
Abdominal pain		
Ankle swelling		
Anxiety		
Allergies		
Chest pain		
Cough with blood		
Cough with phlegm		
Diarrhea/constipation		
Difficulty concentrating		
Dizziness		

	Yes	No
Fatigue		
Frequent urination		
Headaches		
Joint pain		
Memory problems		
Nausea/vomiting		
Painful urination		
Rapid or irregular heartbeat		
Shortness of breath		
Sleep problems		

Please describe any other health concerns