

**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, 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 (continue on reverse side if needed).**