



Patient Under Age 30: Health History

Date: _____ Name: _____ DOB _____

Medications you take regularly:
(Name of medication)

(Dose)

(Daily schedule)

Medications you cannot take or to which you are allergic:

(Name of medication)

(List what happened when you took the medication)

List any operations you have had (i.e. appendectomy 1994):

Please **circle or highlight** below only if you **have had** any of the following health problems:

High blood pressure

Liver problems

Diabetes

Heart problems

Kidney/bladder problems

Migraine headaches

Thyroid disorder

Arthritis

Asthma

Bowel/intestinal problems

Stomach problems/ulcers

Multiple sclerosis

Seizures

Cancer (please list):

Do you smoke or use tobacco? Y N

Do you drink alcohol? Y N

Please circle if an immediate family member (parents or brothers/sisters) has had a history of the following health problems:

High blood pressure

High cholesterol

Alzheimer's disease

Diabetes

Heart attack

Thyroid problems

Obesity

Stroke

Mental illness

Any cancers (please list): _____

For patients under age 18:

Please list what school/grade you are attending:

Please list any sports or hobbies you participate in: _____

Are there any other details regarding your health we should know? If so, please list below:
