

PART D: Personal Health History

Have you had or do you now have.....

YES	NO		YES	NO		YES	NO	
		Asthma			Fainting/dizzy spells			Recurrent colds
		Anemia			Gallbladder/liver problems			Recurrent bronchitis
		Anxiety/depression			Hay fever			Recurrent headaches
		Arthritis			Head injury			Recurrent skin problems
		Chickenpox			Hearing loss			Sexually transmitted diseases
		Cancer			Heart problems			Sickle cell trait
		Convulsions			Hepatitis			Speech problems
		Diabetes			Kidney/bladder problem			Stomach/intestinal problems
		Dental problems			Malaria			Thyroid condition
		Ear infections (frequent)			Measles (what kind?)			Tuberculosis
		Eating disorder			Migraines			Thrombophlebitis
		Epilepsy			Mononucleosis			Other (specify)

Please comment on all positive answers in Part D:

Injuries. Please provide date and comment.

Ankle injury _____ Knee injury _____
 Back injury _____ Leg/foot injury _____
 Broken bones _____ Neck/shoulder injury _____
 Broken nose _____ Skull fracture _____
 Concussion _____ Dislocated shoulder _____

Do you have any injuries that are incompletely healed or for which you are undergoing rehabilitation now? _____

If yes, please comment: _____

General Information

	Y/N	Comment
Have you ever been hospitalized?		
Have you ever had any surgical operations?		
Are you under medical treatment?		
Do you have regular dental checkups?		
Any dental appliances (braces, retainer, etc)?		
Do you wear glasses?		Date of last vision exam:
Do you wear contacts?		
Do you have a physical handicap?		
Do you need special arrangements?		
Do you use tobacco?		What?
Do you consume alcohol?		
Have you ever received psychological help?		

Please list current medications (also vitamins, supplements, herbals) **Dose** **Reason for taking**

Allergies (medicine, food, immunizations, other)

For Women Only (menstrual history)

Age at onset: _____ Number of days duration: _____ Regular Irregular
 Flow: Heavy Medium Light Pain: None Mild Severe