Instilling hope in life by promoting Mental Health and Wellness of Mind, Body, Spirit

MEDICAL HISTORY

NAME: _____ DOB:_____
ADDRESS: _____
PHYSICIAN/PSYCHIATRIST NAME: _____ TEL: _____
ADDRESS: _____

Have you ever been treated for:			Has anyone in your family ever been treated for:		
DISORDER/ILLNESS	**YES**	**NO**	**YES**	**NO**	**COMMENTS**
Heart Disease					
High Blood Pressure					
Stroke					
Diabetes					
Arthritis					
Parkinson's					
Allergies					
Cataracts/other eye problems					
Glaucoma					
Hearing Problems					
Lung Disease					
Skin Disease					
Ulcers					
Colitis					
Growths-Cancer					
Other Major Illnesses					
Major Operations/Surgery					
Sexually Transmitted Disease					
Kidney Disease					
Urinary Problems					
Liver Disease					
Gynecological Problems					
Thyroid Problems					
Psychiatric Disorders					
Have you had:			Has anyone in your family had:		
Blackouts					
Convulsions-Seizures					
Chronic Headaches					
Dizziness/Nausea					
Forgetfulness					
Major Weight loss/gain					
Do you have a history of:			Anyone in your family have a history of:		
Drug Abuse					
Alcohol Abuse					
Physical Abuse					
Sexual Abuse					