

Health History

Name: _____

Date of Birth: ____ / ____ / ____

Address: _____

Sex: Male Female

Emergency contacts

| | |
|----------|--------------------|
| Name: | Phone: () - |
| Address: | Relationship: |

Medical Problems

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Past Surgical History

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Health Care Maintenance and Procedures

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|----------------|-----------------|
| Tetanus: | Foot Examine: |
| Pneumonia Vac: | Eye Examine: |
| Flu Vac: | Dental Examine: |
| Chest X-ray: | |
| EKG: | |

Family History

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|---------|----------|
| Mother: | Sister: |
| Father: | Brother: |

Social History

| | |
|---------------------------|---------------------------|
| Tobacco: Y / N | Alcohol: Y / N |
| Marital Status: Y / N | Children: |
| Occupation: | Birth Place: |
| Exercise: | Diet: |
| Living will: Y / N | EMS-NO CPR OR DNR: Y / N |

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