MED CENTRAL HEALTH RESOURCES, INC.
HEALTH HISTORY

Name _____ Occupation _____
Age _____ Last complete physical exam _____ Last tetanus shot _____
Reason for visit today _____

Have you ever had:	Circle the answer below		
High blood pressure	YES NO	Kidney problems	YES NO
Diabetes (High Sugar)	YES NO	Liver problems	YES NO
Heart condition	YES NO	Seizures	YES NO
Asthma	YES NO	Anxiety	YES NO
Breathing problems	YES NO	Depression	YES NO
Chronic pain	YES NO	Other	_____

Surgeries you have had and dates:
Tonsils _____ Appendix _____ Gall bladder _____ Hernia _____
Hysterectomy _____ Tubal ligation _____ Other _____

Medicines you are currently taking: _____
_____
Pharmacy you use: _____
Allergies: _____

Married YES NO Children YES NO

Do you smoke YES NO If yes,how many packs per day _____
Have you ever smoked YES NO Do you drink alcohol YES NO
Do you or have you ever used drugs, if so, what drugs _____

(Females Only) Date of last menstrual period _____ Date of last pap smear _____

Is there a family history (blood relatives) of any of these:
Cancer YES NO Who _____
Diabetes YES NO Who _____
Heart disease YES NO Who _____
Hypertension YES NO Who _____
Lung disease YES NO Who _____
Other _____

SIGNATURE _____ DATE _____