Medical History
Non-Residential Programs

Client Name: _____ **Client #:** _____ **DOB:** _____ **Date:** _____
Occupation: _____ **Allergies:** _____

List all medications you currently take *(including vitamins and supplements)*. Include backside if needed.

_____ _____ _____
_____ _____ _____

List any major illnesses or injuries *(include approximate dates if possible)*: _____
_____
_____
_____

List any major surgeries *(include approximate dates if possible)*: _____
_____

Do you smoke/vape/use tobacco products: ☐ No ☐ Yes **How much:** _____ **When did you start:** _____

Are you having any issues today: _____

General Issues *(if yes, explain)*	Yes/No	Explanation
Ear, Nose, Throat	☐ Yes ☐ No	
Cardiovascular (Heart, BP, Stroke, etc.)	☐ Yes ☐ No	
Respiratory (Asthma, Emphysema, etc.)	☐ Yes ☐ No	
Gastrointestinal (Stomach, Ulcers, etc.)	☐ Yes ☐ No	
Genital, Kidney, Bladder	☐ Yes ☐ No	
Muscles, Bones, Joints (Arthritis, etc.)	☐ Yes ☐ No	
Skin (Acne, Warts, Skin Cancer, etc.)	☐ Yes ☐ No	
Neurological (Multiple Sclerosis, Headaches, Seizures, etc.)	☐ Yes ☐ No	
Endocrine (Diabetes, Thyroid, etc.)	☐ Yes ☐ No	
Blood, Lymph (High Cholesterol, Anemia, etc.)	☐ Yes ☐ No	
Allergic, Immunologic (Hay Fever, Lupus, HIV/AIDS, Hepatitis, etc.)	☐ Yes ☐ No	
General Health (Fever, Weight Change, Tired, etc.)	☐ Yes ☐ No	
Psychiatric (Depression, Anxiety, PTSD, etc.)	☐ Yes ☐ No	

Significant Family History (Parents, Siblings, Grandparents):

Diabetes	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Strokes	☐ Yes ☐ No	Mental Illness/Substance Use	☐ Yes ☐ No

Comments: _____
_____
_____

_____ _____ _____ _____
Client Signature Date Staff Signature Date

Rev. 9.2018