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HEALTH APPRAISAL

Patient's Name:_____

Email: _____ Date of Birth: _____

Please circle any medical diagnosis that apply for both yourself and your family:

	PATIENT		Family		Who (include deceased members)
*Anemia	no	yes	no	yes	_____
*Arthritis	no	yes	no	yes	_____
*Asthma or Emphysema	no	yes	no	yes	_____
*Cancer (type or location)	no	yes	no	yes	_____
*Chronic Headaches	no	yes	no	yes	_____
*Diabetes	no	yes	no	yes	_____
*Gastritis or Ulcers	no	yes	no	yes	_____
*Heart Disease/Murmurs	no	yes	no	yes	_____
*High Blood Pressure	no	yes	no	yes	_____
*High Cholesterol	no	yes	no	yes	_____
*Kidney Failure/Stones	no	yes	no	yes	_____
*Liver Disease or Alcoholism	no	yes	no	yes	_____
*Psychiatric Disorders	no	yes	no	yes	_____
*Sinusitis	no	yes	no	yes	_____
*Strokes or Seizures	no	yes	no	yes	_____
*Thyroid Disease	no	yes	no	yes	_____

*Disease Not Mentioned _____ _____ _____

_____ _____ _____

Please list any surgeries you have had in the past with approximate date(s).

Please list any hospitalizations with date and hospital name if remembered.

Please list all medications you are currently taking (use other side of form if necessary).

Please list any medication allergies.

If you have ever smoked cigarettes, please indicate how many packs/day and for how long.

Please indicate whether you drink alcohol. If so, what type and how often?

CURRENT MEDICATION LIST

	Name of Medication	Strength or mg	How often
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____
11)	_____	_____	_____
12)	_____	_____	_____

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Signature Date