Medical Health History

Name: **DOB:** **Age:** **Gender:**

Occupation:

Social History:

Tasks and Activities Important to Me:

Current level of physical activity:

Types of physical activity:

Special diet or nutrition need:

Alcohol: **Smoker: Yes/No** **How long:**

Current Health Status:

Current Medications:

Allergies:

Medical Health History

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Current non-drug therapies or treatment:

Average quantity and quality of sleep:

Past Medical History:

Past Surgical History:

Family History:

- Mother
- Father
- Sibling
- Sibling
- Other