MY HEALTH HISTORY

PROVIDED BY HEALTHCHEK
www.healthchek.net
800-915-4583

NAME:_____**DATE OF BIRTH:**_____

PERSONAL PHYSICIAN_____**TELEPHONE #**_____

ADDRESS OF PERSONAL PHYSICIAN_____

DATE OF LAST CONSULT:_____**REASON:**_____

AGE:_____ **HEIGHT:**_____ **WEIGHT:**_____

How would you rate your general health? □ EXCELLENT □ GOOD □ FAIR □ POOR

Do you exercise regularly? □ Yes □ NO

Do you smoke? □ Yes □ NO

Are you overweight? □ Yes □ NO

ARE YOU ALLERGIC TO ANYTHING? □ YES □ NO

_____
_____
_____
_____

BLOOD PRESSURE	
DATE	**BP READING**

LIST MEDICATIONS:

MEDICATION	**DOSAGE**	**HOW OFTEN**

PERSONAL MEDICAL HISTORY:
Indicate if you have had any of the following medical problems.

□ HEART DISEASE □ DIABETES □ HIGH BLOOD PRESSURE
□ HIGH CHOLESTEROL □ STROKE □ THYROID PROBLEM
□ CANCER □ OSTEOPOROSIS □ NEUROLOGICAL DISORDER
□ KIDNEY DISEASE □ ASTHMA/LUNG DISEASE

OTHER MEDICAL PROBLEMS OR OPERATIONS YOU HAVE HAD:

_____
_____
_____
_____
_____