MINISTRY DEVELOPMENT SERVICES
P.O. Box 2634
Indian Trail, NC 28079-2634

HEALTH HISTORY

Information to be Furnished by the Client

Name_________________________________ Birthdate_____________________

Address_________________________________ Occupation__________________

I. FAMILY HISTORY:

	Living		Deceased	
	Age	Health	Age at Death	Cause of Death
Father	_	___	_	___________
Mother	_	___	_	___________
Brothers (B)	_	___	_	___________
and	_	___	_	___________
Sisters (S)	_	___	_	___________
	_	___	_	

If there is a family history of any of the following, please indicate how that person is related to you.

	Relationship		Relationship
Cancer	_______	High Blood Pressure	_________
Diabetes	_______	Heart Disease	_________
Kidney Disease	________		

II. HEALTH HISTORY:

1. Operations, hospitalizations (type and date)______________________________________
____
____
2. Other illnesses (nature and date)____
____
____
3. Have you consulted a physician within the past five years? If so, when and for what reason?____
____
4. Have you ever consulted a psychiatrist, psychologist, or counselor? If so, when and for what reason?____
____

III. PERSONAL HISTORY:

(a) Family:

1. Spouse: Birthdate______ State of Health:_____________________________

2. Children: Birthdate(s) and State of Health:

(a)______________________ (d)________________________________

(b)______________________ (e)________________________________

(c)______________________ (f)________________________________

(b) Personal health habits:

1. Exercise and recreation (indicate frequency)_________________________________

____

2. Medications____

3. Do you smoke? No___. Yes___. Amount _______________________________

4. Do you drink alcoholic beverages? No___. Yes___. Amount _______________

IV. Do you have any of the following symptoms regularly or severely enough to cause you concern?

	Yes	No		Yes	No
Chest Pain	_	_	Abdominal Pain	_	__
Shortness of Breath	_	_	Nausea or Vomiting	_	__
Ankle Swelling	_	_	Diarrhea or Constipation	_	__
Rapid or Irregular Heartbeat	_	_	Nervousness	_	__
Dizziness	_	_	Headaches	_	__
Fainting spells	_	_	Difficulty Concentrating	_	__
Cough productive of Phlegm	_	_	Allergies	_	__
Cough productive of Blood	_	_	Sexual Concerns	_	__
Frequent Urination	_	_	Other health worries	_	__
Painful Urination	_	_	Mental Illness	__	__

V. WOMEN ONLY

1. Menstrual history____

2. Number of pregnancies____

3. Number of living children____

4. Age at menopause____

VI. ADDITIONAL COMMENTS:

____

____