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:

_____

_____