Health Assessment Form

Patient Information

Name: _____ Date of birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Medical History

Please indicate if you have ever been diagnosed with or experienced any of the following medical conditions:

High blood pressure: ☐ Yes ☐ No

Heart disease: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Chronic obstructive pulmonary disease (COPD): ☐ Yes ☐ No

Thyroid disorder: ☐ Yes ☐ No

Depression or anxiety: ☐ Yes ☐ No

Cancer: ☐ Yes ☐ No

Autoimmune disease: ☐ Yes ☐ No

Other (please specify): _____

Current Medications

Please list all medications you are currently taking, including dosage and frequency:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

Allergies

Please indicate if you have any allergies or adverse reactions to the following:

Medications: _____

Foods: _____

Environmental factors (such as pollen, dust, or mold): _____

Family History

Please indicate if any of your family members have been diagnosed with or experienced any of the following medical conditions:

High blood pressure: _____

Heart disease: _____

Stroke: _____

Diabetes: _____

Asthma: _____

COPD: _____

Thyroid disorder: _____

Depression or anxiety: _____

Cancer: _____

Autoimmune disease: _____

Other (please specify): _____

Lifestyle Factors

Please answer the following questions regarding your lifestyle:

Do you smoke or use any tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes/packs per day or how often do you use tobacco products? _____

Do you consume alcohol? ☐ Yes ☐ No

If yes, how many drinks per week? _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercise and how often? _____

Comments

Please use the space below to provide any additional comments or information you would like to share: