Cedar Tree Counseling

HEALTH HISTORY

Date Verified:	Verified By:

PATIENT NAME:

HEALTH HISTORY	YES	NO
Cancer	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Congenital	☐	☐
High Blood Pressure	☐	☐
Palpitations/Flutter	☐	☐
Pacemaker	☐	☐
Respiratory Disease	☐	☐
Chronic Cough	☐	☐
Hay Fever	☐	☐
Shortness of Breath	☐	☐
Asthma	☐	☐
Positive TB test	☐	☐
Seizures / Strokes	☐	☐
Loss of Consciousness	☐	☐
Bleeding Tendency	☐	☐
Digestive Disease	☐	☐
Colitis	☐	☐
Stomach Ulcers	☐	☐
Hiatal Hernia / Reflux	☐	☐
Liver Disease	☐	☐
Genital / Urinary	☐	☐
Kidney Disease	☐	☐
Difficulty Voiding	☐	☐
Menstrual Difficulties	☐	☐
Sexual Dysfunction	☐	☐
Arthritis	☐	☐
Goiter / Thyroid Disease	☐	☐
Migraine Headache	☐	☐
Mental Illness	☐	☐
Depression	☐	☐
Nervous Breakdown	☐	☐

MEDICATIONS
(list medications, including aspirin, laxatives, birth control, cough meds, ALL prescriptions).

NAME	DOSE	Frequency	Last Dose

FAMILY HISTORY	SEX		AGE	ILLNESS or CAUSE OF DEATH
Father				
Mother				
Brothers/Sisters* (circle sex)				
	M	F		
	M	F		
	M	F		
Husband/Wife				
Sons/Daughters* (circle sex)				
	M	F		
	M	F		
	M	F		

ALLERGIES

(Drug or other):

Latex Rubber:	Shellfish:	X-Ray Dye:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No
☐ Unknown	☐ Unknown	☐ Unknown

HEALTH HISTORY	YES	NO	
Previous Hospitalization	☐	☐	
Previous Surgery(ies)	☐	☐	
Serious Illness	☐	☐	
Serious Injury(ies)	☐	☐	
History of Problems with Anesthesia:	☐	☐	
Self	☐	☐	
Family	☐	☐	
Steroids	☐	☐	
Transfusion Reaction	☐	☐	
Pregnant	☐	☐	

COMMENTS

PERSONAL HABITS (check appropriate box)				
☐ Yes	☐ No	Do you regularly smoke?	For How Many Years?	How Many?
		☐ Cigarettes		
		☐ Pipe		
		☐ Cigars		
☐ Yes	☐ No	Do you usually drink 6+ cups of coffee per day?		
☐ Yes	☐ No	Do you regularly drink alcohol?		
		☐ 1 oz./ day ☐ 2 oz./ day ☐ 3 oz./ day ☐ 4+ oz./ day	BEER: ☐ 1 bottle/ day ☐ 2-3 bottles /day ☐ 4+ bottles /day	
☐ Yes	☐ No	Do you have difficulty falling asleep?	If yes, how often:	
☐ Yes	☐ No	Do you exercise regularly?		