Healing Hands Wellness Center

Patient Health History

Patient: _____ **Date:** _____

SOCIAL HISTORY:

Are you? Single Married Divorced Widowed Number of children: _____

Do you exercise? Yes No
If yes, how often? Occasionally 1-2 times a week 3-4 times a week Daily

Do you eat a balanced diet? Yes No

Do you get enough rest? Yes No

Do you drink alcoholic beverages? Yes No
If yes, how often? Occasionally 1-2 times a day 3-4 times a day More frequently

Do you drink caffeinated beverages? Yes No
If yes, how often? Occasionally 1-2 times a day 3-4 times a day More frequently

Do you smoke? Yes No

If yes, how often? Occasionally Less than 1 pack a day 1-2 packs per day More than 2 packs per day

MEDICAL HISTORY:

Childhood illnesses: Mumps Diabetes Cancer Asthma Rheumatic Fever
Please list any serious childhood illnesses or problems not marked above:

_____ Age: _____
_____ Age: _____
_____ Age: _____

Hospitalizations or Surgeries, please list reason and approximate date:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Adult Illnesses or Injuries, please list anything not listed above, including any major falls, work injuries, auto or other types of accidents:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Medications, Vitamins, or Supplements, including Home Remedies, please list all that you have taken in the last six months:

_____

Please list any medications, vitamins or herbs you are allergic to: _____

_____

Any other allergies: _____

_____

FAMILY HEALTH HISTORY:

Mother: in good health cancer diabetes heart problems high blood pressure
respiratory problems stroke kidney problems deceased, age when died _____

Father: in good health cancer diabetes heart problems high blood pressure
respiratory problems stroke kidney problems deceased, age when died _____

Siblings: in good health cancer diabetes heart problems high blood pressure
respiratory problems stroke kidney problems deceased, age when died _____