



ADULT HEALTH HISTORY FORM

Name: _____

Date: _____

ALLERGIES: Check all that apply

___ Eggs ___ Fish & Shellfish ___ Milk or Lactose ___ Peanut
___ Soy ___ Sugar ___ Wheat/Gluten Other _____

SOCIAL HISTORY: Rate the following 1-5 (1 being hardly ever or low & 5 being everyday or high)

___ Caffeine ___ Tobacco ___ Stress Level ___ Alcohol

FAMILY HISTORY: Parent and/or sibling

___ Arthritis ___ High Cholesterol ___ High Blood Pressure ___ Diabetes
___ Thyroid ___ Heart Disease ___ Asthma ___ Allergies
___ Psychiatric ___ Stroke ___ Auto-Immune ___ Scoliosis

Other: _____

RECREATIONAL ACTIVITIES: Check all that apply

___ Golf ___ Basketball ___ Baseball ___ Skiing ___ Hiking ___ Tennis
___ Walking ___ Volleyball ___ Gardening ___ Weights ___ Soccer ___ Travel
___ Football ___ Swimming ___ Biking ___ Elliptical/Treadmill
___ Running ___ Playing w/ kids ___ Video Game Other: _____

MEDICATIONS AND SUPPLEMENTS:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Injuries & hospitalizations: _____

