The CENTER for LONGEVITY and WELLNESS

Medical History Form

NAME: _____ DATE: _____

WEIGHT: _____ HEIGHT: _____ AGE: _____

Hospitalizations / Operations / Year

1._____

2._____

3._____

4._____

5._____

6._____

Drug Allergies

1._____

2._____

3._____

4._____

Present Medications (name – dosage – frequency)

1._____

2._____

3._____

4._____

5._____

6._____

Transfusions – Date (year) _____ Most Recent: _____

Father's age and health _____

Mother's age and health _____

Brothers/Sisters age and health _____

Children _____

Any family history (blood relative) who has had:

Diabetes_____

Elevated blood pressure_____

Heart Disease_____

Cancer_____

Do you smoke Yes or No How much _____

Do you drink alcohol Yes or No How much _____

Do you drink tea Yes or No How much _____

Do you drink coffee Yes or No How much _____