Medical History Form

NVFC Heart-Healthy Firefighter Program

www.healthy-firefighter.org

Please complete this form at home and take to your Doctor.

Name: ______________________________ Phone: ______________

Address: ______________________________

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Doctor: ______________________________ Date of Birth: ______________

FAMILY HISTORY

	If Living		If Deceased		Has any blood relative ever had:	Please Check		
	Age	Health	Age at death	Cause		NO	YES	Who
Father					Heart Disease:			
Mother					Cancer:			
Brothers					Glaucoma:			
					Sugar Diabetes:			
					Tuberculosis:			
					Nervous Disorder:			
Sisters					Epilepsy:			
					Allergy:			
					Stroke:			
					Hardening of the Arteries:			
					High Blood Pressure:			
					Anemia:			

Weight:	**Immunizations:**	**Date:**
Present:	Tetanus	
One Year Ago:	Smallpox	
	Oral Polio	

PERSONAL HISTORY

Have you ever had: (please circle Y for yes or N for no)

Measels	Y N	Polio	Y N	High Blood Pressure	Y N
Mumps	Y N	Meningitis	Y N	Nervous Breakdown	Y N
German Measels	Y N	Kidney Disease	Y N	Hay Fever	Y N
Scarlet Fever	Y N	Gonorrhea	Y N	Asthma	Y N
Diphtheria	Y N	Syphilis	Y N	Ulcer	Y N
Pneumonia	Y N	Anemia	Y N	Prostate Trouble	Y N
Pleurisy	Y N	Yellow Jaundice	Y N	Spastic Bowel	Y N
Rheumatic Fever	Y N	Epilepsy	Y N	Nervous Stomach	Y N
Heart Disease	Y N	Migraine	Y N	Kidney Stone	Y N
Arthritis	Y N	Tuberculosis	Y N	Gall Stones	Y N
Rheumatism	Y N	Sugar Diabetes	Y N	Hemorrhoids	Y N
Cancer	Y N				

LIST ALL HOSPITILIZATIONS

Reason:	Year	Hospital and Doctor

HABITS

Coffee: Cups/day Cigarettes: per day

Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily Medicines: ❑ Yes ❑ No

WOMEN ONLY (Menstrual History)

Age at onset

Cylcle days

Duration days

Are periods regular? ❑ Yes ❑ No

❑ Heavy ❑ Medium ❑ Light

Spotting between periods? ❑ Yes ❑ No

Headaches? ❑ Yes ❑ No

Cramps? ❑ Yes ❑ No

Bleeding after intercourse? ❑ Yes ❑ No

Date of last period

Date of last pap smear

Pregnancies – How many

Number of Children

Number of miscarriages Number of stillbirths

Any trouble with pregnancy? ❑ Yes ❑ No

ALLERGIES	No	Yes
Penicillin, Sulfa		
Other antibiotics		
Aspirin, Codeine		
Other drugs		
Any foods		