



Medical History Form

NVFC Heart-Healthy Firefighter Program

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

Name: _____ Phone: _____

Address: _____

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:			
					Epilepsy:			
Sisters					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)

Have you ever had: (please circle Y for yes or N for no)					WOMEN ONLY (Menstrual History)	
Measels	Y N	Polio	Y N	High Blood Pressure	Y N	Age at onset
Mumps	Y N	Meningitis	Y N	Nervous Breakdown	Y N	Cycle
German Measels	Y N	Kidney Disease	Y N	Hay Fever	Y N	Duration
Scarlet Fever	Y N	Gonorrhea	Y N	Asthma	Y N	Are periods regular? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diphtheria	Y N	Syphilis	Y N	Ulcer	Y N	<input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light
Pneumonia	Y N	Anemia	Y N	Prostate Trouble	Y N	Spotting between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pleurisy	Y N	Yellow Jaundice	Y N	Spastic Bowel	Y N	Headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	Y N	Epilepsy	Y N	Nervous Stomach	Y N	Cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	Y N	Migraine	Y N	Kidney Stone	Y N	Bleeding after intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	Y N	Tuberculosis	Y N	Gall Stones	Y N	Date of last period
Rheumatism	Y N	Sugar Diabetes	Y N	Hemorrhoids	Y N	Date of last pap smear
Cancer	Y N					Pregnancies – How many

LIST ALL HOSPITALIZATIONS

Reason:	Year	Hospital and Doctor

Number of Children	
Number of miscarriages	Number of stillbirths
Any trouble with pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

HABITS

Coffee: _____ Cups/day Cigarettes: _____ per day
 Alcohol: Never Rarely Moderate Daily Medicines: Yes No