JEFFERSON COUNTY
GENERAL HEALTH DISTRICT
(740)283-8530
www.jchealth.com
DR. FRANK J. PETROLA HEALTH COMMISSIONER

Public Health
Prevent. Promote. Protect.

Medical Health History Form

Patient's name:_____ Date of birth:_____

Patient's family doctor:_____ Phone: (_____)_____-_____

Eye Glasses? ☐ No ☐ Yes Exposed to second hand smoke? ☐ No ☐ Yes

List Medications taken on a daily basis:

Name:_____ mg_____ Frequency_____
Name:_____ mg_____ Frequency_____
Name:_____ mg_____ Frequency_____

Please list any chronic health problems, previous hospitalizations, or surgeries:_____

Allergies (If yes, please list)

Food: ☐ No ☐ Yes If yes,_____
Medication: ☐ No ☐ Yes If yes,_____
Bees: ☐ No ☐ Yes If yes,_____

Any history of or difficulty with any of the following? (check if yes):

☐ AIDS/HIV	☐ Depression	☐ Mononucleosis
☐ Anemia	☐ Diabetes	☐ Mumps
☐ Asthma	☐ Drugs/Alcohol	☐ Pneumonia
☐ Bed Wetting	☐ Ear Infections	☐ Rheumatic Fever
☐ Birth Defects	☐ Epilepsy	☐ Sinus Problems
☐ Bladder Problems	☐ Fainting	☐ Speech Problems
☐ Bleeding. Excessive	☐ Hearing Problems	☐ Thyroid Problems
☐ Cancer	☐ Heart Problems	☐ Tuberculosis
☐ Cerebral Palsy	☐ Hepatitis	☐ Urinary Disease
☐ Chicken Pox	☐ Kidney Disease	☐ Vision Problems
☐ Constipation/Diarrhea	☐ Lead Poisoning	☐ Worms
☐ Convulsions	☐ Measles	☐ Other_____

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Date of last Well Child Visit:_____

The information that I have provided is accurate to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status.

Parent/Guardian's Signature:_____ Date:_____