# MEDICAL HISTORY FORM
# NORTH CAROLINA DIVISION OF SOCIAL SERVICES

Name: _____

Home Address: _____

Phone: _____ Date of Birth: _____

## HEALTH HISTORY

| | Any history, past, or present of: | YES | NO |
|---|---|---|---|
| 1 | Head or back injuries | | |
| 2 | Neurological disorders, convulsions, etc. | | |
| 3 | Heart disease, high blood pressure, or rheumatic fever | | |
| 4 | Lung disorders, asthma, tuberculosis | | |
| 5 | Stomach, gall bladder, or other gastro-intestinal disorders | | |
| 6 | Allergies to food, drugs, plants, etc. | | |
| 7 | Blood disorders, anemia, leukemia, etc. | | |
| 8 | Kidney trouble | | |
| 9 | Venereal disease | | |
| 10 | Diabetes or other glandular disorders | | |
| 11 | Surgery | | |
| 12 | Physical disabilities | | |
| 13 | Psychological disorders, mental health diagnosis, drug/substance abuse | | |
| 14 | Other chronic illnesses, diseases, or disorders | | |

If any of the above questions were answered yes, provide explanation:

_____

_____

_____

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_____

What do you consider your state of health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

To the best of my knowledge, the above information is correct.

_____ _____

Signature Date