



A program of Jewish Family Service of Greater Harrisburg Inc.

**PERSONAL HEALTH HISTORY
(To be filled out by applicant)**

Name _____

Do you have or have you ever had any of the following? Give approximate date.

	Past	Present	N/A		Past	Present	N/A
Epilepsy	___	___	___	Asthma	___	___	___
Major accidents	___	___	___	Stroke	___	___	___
High blood pressure	___	___	___	Vision limitation	___	___	___
Heart Disease	___	___	___	Severe headaches	___	___	___
Arthritis	___	___	___	Chronic fatigue	___	___	___
Pneumonia	___	___	___	Thyroid problems	___	___	___
Cancer	___	___	___	Emphysema	___	___	___
Ulcer	___	___	___	Diabetes	___	___	___
Circulatory disease	___	___	___	Orthopedic problems	___	___	___
Alcohol/Drug abuse	___	___	___	Mental Health Issues	___	___	___
Kidney disease	___	___	___	Smoke cigarettes	___	___	___
Hepatitis	___	___	___	Other condition	___	___	___
Muscular disease	___	___	___				

List any hospitalizations. Give reason and date:

Are you currently taking any medication? If yes, give type and reason:

Are you managing any chronic conditions? If so, what do you do to remain healthy?

Do you have or have you had any medical problems that may limit the number and kind of children for whom you could care?

Signature _____
Date _____