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