Metamorphe Health Clinic
3976 E. Harbor Road
Langley, WA 98260
360-221-2050

Mailing address:
P. O. Box 1072
Freeland, WA 98249

Health History

Name:________________________________

Family history (info about your family)

Relation Age Health Age at death/cause

Father ____________________
Mother ____________________
Brother(s) ____________________
____
____
____
____
Sister(s) ____________________
____
____
____

Your Hospitalizations
Year Hospital Reason & Outcome
____
____
____
____
____

Have you ever had a blood transfusion? Yes No
If yes, please give date(s).

Your serious Illnesses/Injuries

Date	**Incident**	**Outcome**

Alleriges (medications or substances)
____
____
____

Check if blood relatives had any of the following

Disease	**Relationship to you**
Arthritis, Gout	
Asthma	
Allergies	
Cancer (type)	
Chemical dependency	
Diabetes	
Heart disease	
Stroke	
High Blood Pressure	
Kidney disease	
Obesity	
Tuberculosis	
Vascular disease	
Other	

Pregnancy History
Year Outcome
____
____
____

Health habits (ck and list how much used)

Caffeine ____________________
Tobacco ____________________
Drugs ____________________
Alcohol ____________________
Other ____________________

Pharmacy (Name and Phone number)
____
____

Do you have a will or durable power of attorney for your medical care in the event of an emergency? Yes No

Current medications and supplements ________
____
____
____
____
____
____
____

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any member of Metamorphe Health Clinic responsible for any errors or omissions that I may have made in the completion of this form.

Signature____**Date**____________________________________
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