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HEALTH HISTORY

Patient's Name _____ Date _____
Physician's Name _____ Number _____ Date of last visit _____
Emergency Contact _____ Number _____

Place a mark on "Y" or "N" to indicate if you have and had any of the following:

AIDS/HIV+	☐ Y	☐ N	Rheumatic fever or Scarlet fever	☐ Y	☐ N
Anemia or other blood disorders	☐ Y	☐ N	Shortness of breath on mild exertion	☐ Y	☐ N
Arteriosclerosis	☐ Y	☐ N	Stomach or duodenal ulcer	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Stroke	☐ Y	☐ N
Artificial joints or Heart Valves	☐ Y	☐ N	Thyroid or parathyroid disorders	☐ Y	☐ N
Asthma	☐ Y	☐ N	Tuberculosis or Emphysema	☐ Y	☐ N
Chest pain on mild exertion	☐ Y	☐ N	Tumor or abnormal growth	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Venereal disease	☐ Y	☐ N
Emotional problems or tension	☐ Y	☐ N			
Epilepsy	☐ Y	☐ N	***Are You:***		
Excessively swollen ankles	☐ Y	☐ N	Presently being treated for any illness	☐ Y	☐ N
Glaucoma	☐ Y	☐ N	Taking any medication regularly	☐ Y	☐ N
Heart trouble or Heart murmur	☐ Y	☐ N	Aware of any recent weight change	☐ Y	☐ N
Hepatitis or Jaundice	☐ Y	☐ N	Often thirsty or urinating	☐ Y	☐ N
High or Low blood pressure	☐ Y	☐ N	Often exhausted and fatigued	☐ Y	☐ N
Hives, skin rash, hay fever	☐ Y	☐ N	Subject to frequent headaches	☐ Y	☐ N
Hospitalization for illness or surgery	☐ Y	☐ N	A heavy smoker	☐ Y	☐ N
Kidney disease or Liver disease	☐ Y	☐ N	Often unhappy and depressed	☐ Y	☐ N
Mitral valve prolapse	☐ Y	☐ N			
Prolonged bleeding due to a small cut	☐ Y	☐ N	***If Female, Are You Now:***		
Prostate disorders (if male)	☐ Y	☐ N	Pregnant	☐ Y	☐ N
Psychiatric treatment	☐ Y	☐ N	Taking birth control pills	☐ Y	☐ N
Radiation treatment	☐ Y	☐ N	In menopause	☐ Y	☐ N
			Past menopause	☐ Y	☐ N

Allergies:
☐ Aspirin ☐ Codeine ☐ Latex ☐ Iodine ☐ Ibuprofen ☐ Sulfa ☐ Erythromycin
☐ Penicillin ☐ Local Anesthetic ☐ Acetaminophen ☐ Sedatives (barbiturates)
☐ Other _____

Medications: Name & Dose For Name& Dose For

_____ _____
_____ _____

Notes _____

_____

Patient Signature: Date:

Recall Date: _____ Recall Date: _____

Recall Date: _____ Recall Date: _____

Recall Date: _____ Recall Date: _____

Recall Date: _____ Recall Date: _____