Health History

Patient Name: **Date of Birth:**

PHYSICIAN'S NAME:_____ **PHONE #:**_____

PREFERRED PHARMACY:_____**PHONE #:**_____

Y	N	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Bones
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Cosmetic Surgery
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Y	N	Conditions
❑	❑	Glaucoma
❑	❑	Hay Fever
❑	❑	Heart Attack
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	High Blood Pressure
❑	❑	HIV + Aids
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Pneumonia
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Shingles
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems

Y	N	Conditions
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers
❑	❑	Venereal Disease
❑	❑	Taken Fen-Phen
❑	❑	Do you smoke or use tobacco?

If female, please answer the following:

Y	N	
❑	❑	Are you taking Birth Control Pills
❑	❑	Are you pregnant?
❑	❑	Are you nursing?

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ARE YOU ALLERGIC TO:

Y	N	
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Anesthetics
❑	❑	Erythromycin
❑	❑	Metal
❑	❑	Latex
❑	❑	Penicillin
❑	❑	Tetracycline

ARE YOU CURRENTLY ON:

Y	N	
❑	❑	Coumadin
❑	❑	Plavix
❑	❑	Warfarin
❑	❑	Aspirin

LIST ALL CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

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Y	N	
❑	❑	ARE THERE ANY OTHER DISEASE, CONDITIONS, OR PROBLEMS THAT YOU THINK WE NEED TO BE AWARE OF?

EXPLAIN:_____

❑ ❑ ARE YOU UNDER THE CARE OF A DOCTOR NOW?

EXPLAIN:_____

❑ ❑ YOUR HEALTH INFORMATION CAN BE CRUCIAL. DO YOU AUTHORIZE THE INFORMATION TO BE TRUE TO THE BEST OF YOUR KNOWLEDGE

PATIENT/GUARDIAN SIGNATURE:_____

DOCTOR SIGNATURE:_____**DATE:**_____