Patient Health History

Medical Health History:

1. Describe your present health___ Excellent ___ Good ___ Fair ___ Poor Height ____ Weight _____
2. List your current Physician(s): a._____ Type_____
   b._____ Type_____
3. Date of your last physical exam _____/_____/_____ Purpose_____
4. Are you aware of any changes in your general health in the last year? No Yes _____
5. Have you been hospitalized for illness or surgery in the past two years? No Yes _____
6. Have you been under a medical doctor's care during the past two years? No Yes _____
7. Have you ever had excessive bleeding that required special treatment? No Yes _____
8. Is there any history of diabetes in your family? No Yes _____
9. Are you on a special or restricted diet of any kind? No Yes _____
10. Do you smoke? ___ No ___ Yes How much?_____ How long? _____
11. Do you consume drinks with caffeine? ___ No ___ Yes How many?_____
12. Do you consume alcoholic drinks? ___ No ___ Yes How many drinks per day _____ per week_____
13. Are you taking blood thinners including aspirin? ___ No ___ Yes
13. List all medications you are now taking (include over the counter)_____

_____

List all medications you are allergic to: _____

Indicate which of the following you have had or presently have, circle yes or no:

A Nervous Person	No/Yes	Epilepsy or Seizures	No/Yes	Liver Disease	No/Yes
AIDS	No/Yes	Fainting or Dizzy Spells	No/Yes	Low Blood Pressure	No/Yes
Allergies or Hives	No/Yes	Frequent Headaches	No/Yes	Persistent Cough	No/Yes
Anemia	No/Yes	Frequent Thirst/Urination	No/Yes	Psychiatric Care	No/Yes
Angina	No/Yes	Glaucoma	No/Yes	Radiation Treatment	No/Yes
*Arthritis Rheumatism	No/Yes	Hay Fever	No/Yes	Rheumatic Fever	No/Yes
*Artificial Joint (Knee, Hip)	No/Yes	Heart Disease or Attack	No/Yes	Scarlet Fever	No/Yes
*Artificial Heart Valve	No/Yes	Heart Murmur	No/Yes	Shortness of Breath	No/Yes
Asthma	No/Yes	Heart Pacemakers	No/Yes	Sinus Trouble	No/Yes
Blood Transfusions	No/Yes	Heart Surgery	No/Yes	Stroke	No/Yes
Birth control pills	No/Yes	Heart Trouble	No/Yes	Taking hormone med.	No/Yes
Cancers or Tumors	No/Yes	Hemophilia	No/Yes	Thyroid Disease	No/Yes
Chemotherapy	No/Yes	Hepatitis	No/Yes	Tuberculosis	No/Yes
Congenital Heart Lesions	No/Yes	High Blood Pressure	No/Yes	Ulcers	No/Yes
Diabetes	No/Yes	HIV Positive	No/Yes	Weight Loss/Gain	No/Yes
Drug/Alcohol Addict	No/Yes	If female, are you pregnant?	No/Yes		
Emphysema	No/Yes	Kidney or Bladder Trouble	No/Yes		

*** If yes to any of starred conditions please call prior to appointment.**

Do you have any medical conditions or diseases we should know about? No/Yes

Explain: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the Doctor on or before my next appointment, without fail.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____