

HEALTH HISTORY

Patient's name: _____ Date: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Swelling, Feet/Ankles	<input type="checkbox"/> Y	<input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Swollen Neck Glands	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis, Rheumatism	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis Type _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial Heart Valves	<input type="checkbox"/> Y	<input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial Joints	<input type="checkbox"/> Y	<input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	HIV Positive	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tumor or growth on head or neck	<input type="checkbox"/> Y	<input type="checkbox"/> N
Back Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaw Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Venereal Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Weight Loss, unexplained	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Chemical Dependency	<input type="checkbox"/> Y	<input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Chemotherapy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Circulatory Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Cortisone Treatment	<input type="checkbox"/> Y	<input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Cough, persistent or bloody	<input type="checkbox"/> Y	<input type="checkbox"/> N	Radiation Treatment	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Respiratory Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Emphysema	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Epilepsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Fainting or dizziness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Skin Rash	<input type="checkbox"/> Y	<input type="checkbox"/> N			
			Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Women:
 Are you pregnant? Y N
 Due date _____
 Are you nursing? Y N

**Other medical information,
 not listed above?**

MEDICATIONS

List medications you are currently taking:

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Barbiturates(sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex
<input type="checkbox"/> Other _____	

Physicians Name: _____ Phone#: _____

Thank you for providing us this important information

Returning patients, has there been any change in your health since your last visit?

If so, what has changed? _____

New medications? _____

Patient signature _____ Date _____

Doctor's signature _____ Date _____

If so, what has changed? _____

New medications? _____

Patient signature _____ Date _____

Doctor's signature _____ Date _____