

HEALTH HISTORY

General Information

PHYSICIAN'S NAME _____

PHONE # _____

DATE OF LAST VISIT _____

DO YOU HAVE A CURRENT MEDICAL PROBLEM? Y N

EXPLAIN? _____

Please list medications you are currently taking:

Have you ever had any of the following diseases or medical problems?

Cardiovascular System

HIGH / LOW BLOOD PRESSURE YES NO

CONGENITAL HEART DISEASE YES NO

MITRAL VALVE PROLAPSE YES NO

RHEUMATIC FEVER YES NO

HEART MURMURS YES NO

HEART SURGERY YES NO

STENTS/ ARTIFICIAL VALVES YES NO

HEART ATTACK YES NO

DATE _____

STROKE YES NO

DATE _____

SHORTNESS OF BREATH YES NO

SWOLLEN ANKLES YES NO

PACEMAKER YES NO

ANGINA (CHEST PAIN) YES NO

BLOOD THINNERS YES NO

Respiratory System

ASTHMA YES NO

EMPHYSEMA, TUBERCULOSIS (TB) YES NO

CHRONIC BRONCHITIS YES NO

PERSISTANT COUGH/COLDS YES NO

SINUS TROUBLE YES NO

Digestive System

DIABETES TYPE I/ TYPE II YES NO

MONITOR BLOOD SUGAR DAILY YES NO

THYROID DISEASE YES NO

ENDOCRINE IMBALANCE YES NO

KIDNEY DISEASE/MALFUNCTION YES NO

LIVER DISEASE/JAUNDICE YES NO

HEPATITIS A / B / C YES NO

CHRONIC DIARRHEA/CONSTIPATION YES NO

STOMACH ULCERS YES NO

CHRONIC DRY MOUTH YES NO

Nervous System

EPILEPSY OR SEIZURES YES NO

DEPRESSION YES NO

FAINING OR DIZZY SPELLS YES NO

EMOTIONAL PROBLEMS YES NO

Bone and Joints

ARTHRITIS OR RHEUMATISM YES NO

ARTIFICIAL JOINTS YES NO

DATE OF SURGERY : _____

OSTEOPOROSIS YES NO

BISPHOSPHONATE THERAPY YES NO

FOR HOW LONG? _____

WHICH MEDICATION: Fosamax, Actonel, Boniva,

Skelif, Didronel, Aredia or Zometa

Blood Disorders

ANEMIA/HEMOPHILIA YES NO

EXCESSIVE BLEEDING/BRUISING YES NO

HIV POSITIVE YES NO

BLOOD TRANSFUSION YES NO

Cancer

MALIGNANCY YES NO

WHICH TYPE _____

CHEMOTHERAPY YES NO

RADIATION THERAPY YES NO

DRUG THERAPY YES NO

Other

GLAUCOMA / CATARACTS YES NO

CONTACT LENSES YES NO

HARD OF HEARING YES NO

TOBACCO USE YES NO

ALCOHOL USE YES NO

SEXUALLY TRANSMITTED DISEASE YES NO

EATING DISORDER YES NO

Women Only-Are you currently?

PREGNANT DUE DATE _____ YES NO

NURSING YES NO

BIRTH CONTROL PILLS YES NO

HORMONAL THERAPY YES NO

Are you allergic to any of the following:

PENICILLIN YES NO

CODEINE YES NO

SULFA DRUGS YES NO

LATEX YES NO

DENTAL ANESTHETIC YES NO

LIST OTHER ALLERGIES _____

Please list any other medical condition(s) and / or serious illnesses that we should be aware of: _____

I confirm the information provided today is correct to the best of my knowledge:

SIGNATURE _____

DATE _____