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
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: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check ( ) if you have had any of the following:

☐ AIDS	☐ Chemotherapy	☐ Hemophilia	☐ Radiation Treatment
☐ Anemia	☐ Circulatory Problems	☐ Hepatitis	☐ Respiratory Disease
☐ Arthritis, Rheumatism	☐ Congenital Heart Lesions	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Artificial Heart Valves	☐ Cortisone Treatments	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Bleeding Abnormally	☐ Headaches	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Blood Disease	☐ Heart Murmur	☐ Nervous Problems	☐ Ulcer
☐ Cancer	☐ Heart Problems	☐ Pacemaker	☐ Venereal Disease
☐ Chemical Dependency	Describe _____	☐ Psychiatric Care	

*** If yes to any of checked 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: _____