Patient's name:_____ **Date:**_____

Health History

Your Physician's name:_____ Office Phone No.:_____

Date of last exam: _____

Please circle "Y" if you have had or "N" if you have not had any of the following:

Y N AIDS/HIV (or otherwise compromised immune system)
Y N Allergies
Y N Anemia
Y N Angina
Y N Arthritis/Rheumatoid Arthritis
Y N Artificial Heart Valve
Y N Artificial Joints/Prosthetic Joint (less than 2 yrs.old)
Y N Asthma
Y N Back Problems
Y N Bladder Trouble
Y N Bleeding Abnormally, with extractions or surgery
Y N Blood Disease
Y N Blood Transfusion
Y N Cancer (where?_____ When?_____)
Y N Chemical or Drug Dependency Recovering?_____
Y N Chemotherapy
Y N Chest pains
Y N Circulation Problems
Y N Colitis
Y N Congenital Heart Disease
Y N Cortisone Treatments
Y N Cough, Persistent or Bloody
Y N Chronic Cough
Y N Diabetes (insulin dependent/poorly controlled)
Y N Dialysis with AV shunt
Y N Emphysema
Y N Endocarditis
Y N Epilepsy
Y N Fainting or dizziness
Y N Frequent Thirst
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Murmur

Do you wear contact lenses? Y / N

Y N Heart Problems/Valvular Heart Disease
Y N Hepatitis (Type:____)
Y N Herpes
Y N High Blood Pressure
Y N Jaundice
Y N Jaw Pain
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse(MVP)w/regurgitation
Y N Nervous Problems
Y N Organ Transplant
Y N Pacemaker
Y N Psychiatric Care
Y N Radiation Treatment
Y N Respiratory Disease
Y N Respiratory Problem
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Shortness of Breath
Y N Sinus Trouble
Y N Skin Rash
Y N Special Diet
Y N Stroke (when?_____)
Y N Surgical Pulmonary Shunt
Y N Swollen Feet or Ankles
Y N Swollen Neck Glands
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis
Y N Tumor or Growth on Head or Neck
Y N Ulcer
Y N Venereal Disease
Y N Weight Loss, unexplained

Other: _____

Women:

Are you Pregnant? Y / N Due Date: _____

Are you Nursing? Y / N

Taking Birth Control Pills? Y / N

Office use: blood pressure

Medications/Dosages:

List medications (*with the dosage)* you are currently taking:

_____

_____

_____

_____

Is there a Family History of ….

Heart Disease? Y / N
Stroke? Y / N
Diabetes? Y / N
Respiratory Infections? Y / N
Osteopenia? Y / N
Preterm/Low Birthweight baby? Y / N

Allergies: Are you allergic to or have had any reaction to the following:

Y N Aspirin
Y N Barbiturates, Sedatives, Sleeping pills
Y N Codeine or other narcotics
Y N Iodine
Y N Latex rubber
Y N Local anesthetic
Y N Penicillin or other antibiotics
Y N Sulfa drugs
Y N Any food or medication
Y N Any metals (mercury, nickel, etc.)
____ Other:_____

Patient/Guardian Signature: _____ **Date:**_____