

Name: _____ Date: _____



Patient Health History:

Physicians Name: _____ Phone: _____

Are you allergic to any of the following?(please circle all that apply): **Yes** **No**

Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Latex Metals Dental Anesthetics Other _____

Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.

- | | | | |
|---|--|---|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Valve Replacement | <input type="checkbox"/> <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Growths/Tumors | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders/Anxiety |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Diabetes Type: _____ | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction/Alcohol |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Blood Disease/Disorder | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Menopause | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> <input type="checkbox"/> Herpes Lesions | <input type="checkbox"/> <input type="checkbox"/> Arthritis Type: _____ | <input type="checkbox"/> <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> <input type="checkbox"/> Hepatitis Type: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Thyroid Type: _____ | <input type="checkbox"/> <input type="checkbox"/> HPV Virus |
| <input type="checkbox"/> <input type="checkbox"/> Cold Sores | <input type="checkbox"/> <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> <input type="checkbox"/> History of Endocarditis | | | |

Joint Replacement: Y N Type: _____ Date: _____ **Pre-Med Required:** Y N

Cancer: Y N Type: _____ Date: _____ **Chemotherapy:** Y N **Radiation:** Y N

Do you have any other health problems or conditions? YES NO

If yes, please explain: _____

Are you taking any medications or vitamins at this time? YES NO

If yes, please list medications/vitamins below:

_____	_____
_____	_____
_____	_____
_____	_____

Have you been admitted to a hospital or needed emergency care during the past year? YES NO

If yes, please explain: _____

Are you now under the care of a specialist? YES NO Name of Physician: _____

Do you smoke/use tobacco products? YES NO Type: _____ How much per day?: _____

WOMEN: N/A

Are you pregnant or nursing? YES NO Due Date: _____ **Are you taking birth control?** YES NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____