Health History Information

Patient's Name ___________________________________ Date of Birth ____-____-______

Primary phone ____-_____-_______ Secondary phone ____ -_____- _______

Work phone ____ - _____- ______

Do you or have you had any of the following? (Please mark or circle all that apply)

- ❑ Rheumatic fever or Rheumatic heart disease
- ❑ Hepatitis *Type?* _________________ *When?* ____________________________
- ❑ Artificial joints *Where?* _________________*When?* ____________________________
- ❑ Heart murmur or mitral valve prolapse
- ❑ Hemophilia or other bleeding disorder
- ❑ AIDS, HIV, or venereal disease *When contracted?* ______________________________________
- ❑ Heart problems *Please describe* ____
- ❑ Organ transplant *Which organ(s)?* _______________ *When?* ______________________
- ❑ Diabetes *Controlled by: diet, oral medications, injections*
- ❑ High or low blood pressure *Average reading?* _____/______
- ❑ Radiation treatments *What condition?* ____

Asthma Arthritis Stroke (*when*? ________) Psychiatric care/medications

Back problems Sinus problems Ulcers (*when*? ________) Chemical dependency

❑ *Please mark the box if you do not have any health problems.*

Please list any medications that you have had an allergic reaction or write "*NONE*": (i.e. penicillin)

_________________ ___________________ ___________________ ____________________

Are you pregnant or nursing? *yes or no* *if yes,* when is your due date?____________________________

Have you been hospitalized or had major surgery in the last 5 years? *yes or no*

If yes, please note the type of surgery and the date ____

_____________________________________ ____

Do you use tobacco products? y*es or no* if *yes*, what type? ________________ How much? ____________)

Please list your physician's name ________________________________ Phone # _____-_____-_____

When was the approximate date of your last visit? ____

Please list all of your medications below or write "*NONE*"

	Drug name	Dosage	Reason
1.	_____________________________	__________________	__________________________________
2.	_____________________________	__________________	__________________________________
3.	_____________________________	__________________	__________________________________
4.	_____________________________	__________________	__________________________________
5.	_____________________________	__________________	__________________________________
6.	_____________________________	__________________	__________________________________
7.	_____________________________	__________________	__________________________________

Patient's Signature ____**Date** ______-______-______

Updates	Staff initials	Significant changes	Updates	Staff initials	Significant changes
_____-____-____	______	__________________	____-____-____	______	__________________
_____-____-____	______	__________________	____-____-____	______	__________________