HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

Physicians Name _____ Address _____

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?.....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Congenital Heart Disease / Defect?.....Y N
   - B. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High or Low Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?).....Y N
     (Please underline all that apply)
   - C. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, TB)?.....Y N
   - D. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .....Y N
   - E. Bleeding Disorder, Anemia, Leukemia, Blood Transfusion? Do you bruise easily?.....Y N
   - F. Liver Disease (Jaundice, Hepatitis)? .....Y N
   - G. Kidney Disease? .....Y N
   - H. Diabetes?.....Y N
   - I. Osteoporosis/Osteopenia?.....Y N
   - J. Neurological conditions?Ex: Parkinsons, Huntingtons……..Y N
   - K. Thyroid Disease (Goiter / Hypo / Hyper)? .....Y N
   - L. Arthritis or any other inflammatory disease? .....Y N
   - M. Stomach Ulcers, Colitis or GI disorder? .....Y N
   - N. Glaucoma?.....Y N
   - O. Implants placed anywhere in your body? (Heart Valve, Hip, Knee) .....Y N
   - P. Has or had cancer?.....Y N
     *Type / When?_____
     *Treatment: Chemo / Radiation / Surgery?.....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system?.....Y N
   - S. AIDS or tested HIV positive?.....Y N
   - T. Sexually transmitted disease?.....Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)?.....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N

All responses are kept confidential

- D. High Blood Pressure medications?.....Y N
- E. Steroids? (Cortisone, etc)……Y N
- F. Tranquilizers? …… Y N
- G Insulin or Oral Anti-Diabetic drugs?.....Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? .....Y N
- J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

_____

_____

_____

_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)?.....Y N
   - B. Penicillin or other antibiotics?.....Y N
   - C. Sedatives, Barbiturates? .....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers?.....Y N
   - F. Latex or Metal Products? .....Y N
   - G. Other allergies or reactions? Please, list .....Y N

   _____

   _____
10. Do you smoke or chew Tobacco? .....Y N
    How much per day? _____
11. Is there any past or current history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
13. Do you wish to talk to the doctor privately about anything?.....Y N
14. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N
    - B. Are you nursing? .....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Clinician's Initials _____

Annual Update: I have read my Health History and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Clinician' s Initials
Date	Exceptions or changes	Patient's Signature	Clinician's Initials