**HEALTH HISTORY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, please contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the boxes of the following problems or conditions that you have or have had in the past:

|  |  |  |
| --- | --- | --- |
| \_\_\_Rheumatic Fever | \_\_\_Thyroid Disease | \_\_\_Seizure Disorder |
| \_\_\_Heart Disease | \_\_\_Anemia | \_\_\_Kidney Disease |
| \_\_\_Heart Murmur (MVP) | \_\_\_Bleeding problems | \_\_\_Depression/Anxiety |
| \_\_\_Congenital heart lesions | \_\_\_Diabetes | \_\_\_Cold sores/fever blisters |
| \_\_\_Heart surgery | \_\_\_Liver disease | \_\_\_Glaucoma |
| \_\_\_Pacemaker | \_\_\_Hepatitis \_\_ A \_\_ B \_\_ C | \_\_\_High blood pressure |
| \_\_\_Artificial Joint/Heart Valve | \_\_\_HIV/AIDS | \_\_\_Neurological problems |
| \_\_\_History of Endocarditis | \_\_\_Sinus trouble/Allergies | \_\_\_Steroid treatment |
| \_\_\_Stroke | \_\_\_Asthma | \_\_\_Eating Disorders |
| \_\_\_Angina pectoris | \_\_\_Emphysema | \_\_\_Use of oral contraceptives |
| \_\_\_Tumors/Growths | \_\_\_Tuberculosis | \_\_\_Pregnant |
| \_\_\_Cancer/Chemotherapy | \_\_\_Radiation Therapy | \_\_\_Nursing |

Other Conditions not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies or adverse reactions you have had to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List **all** prescription medications you are presently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized in the past five years?: \_yes \_no Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been a drug or substance abuser?: \_\_\_ yes \_\_\_ no

Do you smoke or use chewing tobacco?: \_\_\_ yes \_\_\_ no How much?: \_\_\_\_\_\_\_\_

Is there anything that you would like to discuss with the Doctor in private? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**