PATIENT'S HEALTH HISTORY

Patient's name ↑	Today's date ↑
Reason for visit ↑	Other family members seen in our office ↑

MEDICAL HISTORY (Please check all that apply)

__ High blood pressure
__ Heart attack
__ Palpitations/irregular pulse
__ Heart murmur
__ Other heart trouble
__ Abnormal EKG
__ Rheumatic fever
__ Stroke
__ Peripheral vascular disease
__ Shortness of breath
__ COPD or emphysema
__ Asthma
__ Sleep apnea
__ Major allergies
__ Hepatitis
__ Other liver disease

__ Bowel problems
__ Ulcers/gastritis
__ Diabetes
__ Thyroid problems
__ Kidney (or renal) disease
__ Bladder problems
__ Prostate problems
__ Seizure disorders
__ Migraines
__ Insomnia
__ ADHD
__ Depression
__ Psychiatric care
__ Chronic fatigue syndrome
__ Fibromyalgia
__ Arthritis

__ Skin disorders (i.e. Lupus)
__ Anemia
__ Bleeding tendency or disorder
__ Phlebitis
__ DVT or pulmonary embolus
__ Facial herpes (fever blisters)
__ Dry eyes
__ Bell's palsy
__ Glaucoma
__ Other eye disorders
__ Cancer – type: ________________________
__ Blood transfusion(s)
__ Positive blood test – HIV/hepatitis
__ Loose teeth
__ Dentures/bridges/caps/crowns
__ Piercings other than ears - ________________

MEDICATIONS

Please list all medications you are currently taking (include birth control pills, aspirin, sinus medications, over-the-counter medicines, vitamins, supplements, etc.)

Drug/Supplement	Dosage	Frequency	Taken For

Please list physicians you see regularly: ____

Please list all hospitalizations and operations (including cosmetic procedures): ______________________
____
____

Is there anything else significant we should know about your personal or family history? ______________
____
____
____

Please see more health related questions on the next page.

PATIENT'S HEALTH HISTORY (CONTINUED)

Patient's name ↑	Today date

MISCELLANEOUS

Do you consider your general health to be (circle one): excellent good fair poor

Do you have allergic reaction to any medicines? Yes No If yes, list: ___________________________

Do you have allergic reaction to any adhesive tapes? Yes No

Do you have allergic reaction to any topical medicines (creams, ointments, etc.)? Yes No

Do you exercise (circle one): daily 3-5 times a week weekly hardly ever

Do you need to take antibiotics for prophylaxis before dental work? ______

Does your religious affiliation (i.e., Jehovah's Witness) prevent use of blood products? Yes No

Have you had recent (past two years) weight changes? Yes No If yes, how much? ______________

Do you make thick scars or keloids? Yes No

Do you smoke? Yes No If yes, amount per day: ____

Have you smoked in the past? Yes No If yes, number of years and amount: ____________________

Do you have any sensitivity to rubber or latex products? Yes No

Have you had any problems with anesthesia in the past? Yes No

Do you drink alcoholic beverages? Yes No If yes, how much per week? _______________________

When was your last physical? ______________________ By whom? ___________________________

When was your last eye exam? ____________________ By whom? ___________________________

When/where was your last chest X-ray? __________________________ EKG? ____________________

When/where was your last mammogram? ____

Have you had blood work done in the last year? Yes No By whom? _________________________

FOR OFFICE USE ONLY IN THIS BOX

Height ___________ Weight ____________ B/P _________________

Assessment:

____

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