Health History Form

Name:_____ Birthdate:_____

First Middle initial Last M M / D D / Y Y Y Y

Address:_____

Street City State Zip

Do you have, or have you had, any of the following? (Select yes or no)

Heart Problems

Chest Pains ( ) yes ( ) No
Shortness of Breath ( ) yes ( ) No
Blood Pressure problems ( ) yes ( ) No
Heart Murmur ( ) yes ( ) No
Heart Valve Problem ( ) yes ( ) No
Taking heart medication ( ) yes ( ) No
Rheumatic Fever ( ) yes ( ) No
Pace maker ( ) yes ( ) No
Artificial heart valve ( ) yes ( ) No

Intestinal Problems

Easy bruising ( ) yes ( ) No
Frequent nosebleeds ( ) yes ( ) No
Abnormal bleeding ( ) yes ( ) No
Blood disease (anemia) ( ) yes ( ) No
Ever require a blood transfusion ? ( ) yes ( ) No

Allergy Problems

Hay Fever ( ) yes ( ) No
Sinus Problems ( ) yes ( ) No
Skin rashes ( ) yes ( ) No
Taking Allergy Medicine ( ) yes ( ) No
Asthma ( ) yes ( ) No

Women

Taking contraceptives ( ) yes ( ) No
Are you nursing? ( ) yes ( ) No
Are you pregnant? ( ) yes ( ) No
If so, how many weeks? _____
Have you reached menopause? ( ) yes ( ) No

Other

Ulcers ( ) yes ( ) No
Weight gain or loss ( ) yes ( ) No
Special diet ( ) yes ( ) No
Constipation/ Diarrhea ( ) yes ( ) No
Kidney or bladder problems ( ) yes ( ) No
Swollen glands ( ) yes ( ) No

Bone or Joint Problems

Arthritis ( ) yes ( ) No
Back or neck pain ( ) yes ( ) No
Joint replacement (e.g., total hip, pins or implants? ( ) yes ( ) No
Which Joint was replaced: _____
When was replacement: _____

Diabetes

Urinate more than 6 times a day? ( ) yes ( ) No
Thirsty or mouth is dry much of the day? ( ) yes ( ) No
Family history of diabetes ( ) yes ( ) No
Do you have Diabetes? ( ) yes ( ) No

During the past 12 months, have you taken any of the following?

High blood pressure Meds ( ) yes ( ) No
Blood Thinners (e.g. Coumadin) ( ) yes ( ) No
Antibiotics ( ) yes ( ) No
Sulfa drugs ( ) yes ( ) No
Insulin, Orinase, or similar drug ( ) yes ( ) No
Aspirin ( ) yes ( ) No
Digitalis or drug for heart trouble ( ) yes ( ) No
Nitroglycerin ( ) yes ( ) No
Cortisone (steroids) ( ) yes ( ) No
Natural Remedies ( ) yes ( ) No
Nonprescription meds ( ) yes ( ) No
Barbiturates, sedatives, or Aspirin, Acetaminophen, yes ( ) No

Fainting or Seizures ( ) yes ( ) No
Stroke (s) ( ) yes ( ) No
Frequent or severe headaches ( ) yes ( ) No
Thyroid problems ( ) yes ( ) No
Persistent cough ( ) yes ( ) No
Snore, gasp or choke while sleeping ( ) yes ( ) No
Premedication required by physician? ( ) yes ( ) No
Respiratory disease or TB ( ) yes ( ) No
Cancer/Tumor ( ) yes ( ) No
Hepatitis ( ) yes ( ) No
Jaundice, or liver trouble ( ) yes ( ) No

Blood Problems

HIV-positive/AIDS ( ) yes ( ) No
Herpes or other STD ( ) yes ( ) No
Epilepsy or other neurological disease? ( ) yes ( ) No
Glaucoma ( ) yes ( ) No
Do you wear contact lenses? ( ) yes ( ) No
History of head injury? ( ) yes ( ) No
History of alcohol/drug abuse? ( ) yes ( ) No
Do you drink alcohol? ( ) yes ( ) No
If so, how much? _____
Do you smoke? ( ) yes ( ) No
If so, how much? _____
Other: _____

Are you allergic, or have you reacted adversely to any of the following? If so, mark yes.

Local anesthetics ( ) yes ( ) No
Penicillin or Amoxicillin ( ) yes ( ) No
Other antibiotics ( ) yes ( ) No
Sulfa Drugs ( ) yes ( ) No
Sleeping pills ( ) yes ( ) No Tranquilizers ( ) ( ) yes ( ) No
Ibuprofen( ) yes ( ) No
Codeine, Demerol, or other narcotics ( ) yes ( ) No
Reaction to metals ( ) yes ( ) No
Latex or rubber dam ( ) yes ( ) No

List all Medications you are taking currently: _____

_____

_____

_____

Patient Signature **Date**