HEALTH HISTORY

Patient Name: ____ ____ ____ ____

Last | First | MI | Preferred Name

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Artificial Joint
- ☐ Bruise Easily
- ☐ Cold Sores/Fever Blisters
- ☐ Dementia
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatments
- ☐ Scarlet Fever
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Tumors or Growths
- ☐ Alzheimer’s Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Disorder
- ☐ Drug Addiction
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Pacemaker
- ☐ Herpes
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Parathyroid Disease
- ☐ Renal Dialysis
- ☐ Shingles
- ☐ Spina Bifida
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Anaphylaxis
- ☐ Artificial Heart Valve
- ☐ Blood Disorders
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Excessive Thirst
- ☐ Hay Fever
- ☐ Heart Disease/Trouble
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Osteoporosis/Bisphosphonate Use
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Stomach/Intestinal Problems
- ☐ Tuberculosis
- ☐ Venereal Disease

Please list any other medical condition not listed above:

Medical Physician’s Name and Facility Name:

____

____

____

Are you currently under a physician’s care?

☐Yes ☐No

If yes, please explain:______________________

____

____

____

Have you ever been hospitalized or had a major operation?

☐Yes ☐No

If yes, please explain: ______________________

____

____

____

Please list all prescription and over the counter medications that you take:______________________________

____

____

____

____

____

Do you use tobacco?

☐Yes ☐No

Are you pregnant?

☐Yes ☐No

Do you take a Pre-medication before appointments?

☐Yes ☐No **If yes, why?** ______________________

Orthopedic/Heart Physician’s Name & Facility Name:

____

Please list any allergies:______________________

____

____

____

I acknowledge I have answered all questions to the best of my ability.

Patient Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________