C O N F I D E N T I A L

PATIENT HEALTH HISTORY

Today's Date: __________________

Patient Name: ____ **DOB:** _______________________

Medical History

Check (√) if you have or have had any of the following:

❑ Anemia	❑ Glaucoma	❑ Radiation Treatment
❑ Arthritis, Rheumatism	❑ Headaches	❑ Respiratory Problems
❑ Asthma	❑ Heart Problems: Describe:	❑ Rheumatic Fever
❑ Back Problem	❑ Hemophilia	❑ Shortness of Breath
❑ Blood Disorders	❑ Hepatitis	❑ Sinus Problems
❑ Cancer (Site):	❑ High Blood Pressure	❑ Stroke
❑ Chemotherapy	❑ HIV Positive	❑ Swelling of feet or ankles
❑ Cough, Persistent	❑ Jaw Pain	❑ Thyroid Problems
❑ Cough with Bloody Sputum	❑ Kidney Disease	❑ Tobacco/Cigarette Habit
❑ Dizziness	❑ Liver Disease	❑ Tuberculosis
❑ Drug Dependency:	❑ Mitral Valve Prolapse	❑ Ulcer
❑ Diabetes	❑ Pace Maker	❑ Venereal Disease
❑ Epilepsy	❑ Psychiatric Care	❑ Others:
❑ Fainting		

Have you had any serious illnesses or operations: ❑ yes ❑ No

If yes, describe:____

Have you ever had a blood transfusion: ❑ yes, date:__________________ ❑ No

Medications	**Allergies**	
List medications you are currently taking:	❑ Aspirin	❑ Penicillin
	❑ Barbiturates	❑ Sulfa
	❑ Codeine	❑ Other
	❑ Local Anesthetic	
Pharmacy Name:	Describe reactions:	
Phone Number:		

The above information is accurate and complete to the best of my knowledge. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:____ **Date:**____________________