HEALTH HISTORY

Personal Physician Name:_____ **Phone#**_____

Are you in good health? _____ **Yes** _____ **No**

Are you allergic to any medications OR have you ever had any bad reactions to any drugs or medicines?
_____ **Yes** _____ **No** **If YES, please list:**_____

Are you currently taking any medications including vitamins, aspirin, anti-inflammatory, etc.?
_____ **Yes** _____ **No** **If YES, please list:**_____

_____

Do you smoke or chew tobacco? _____ **No** _____ **Yes** **How much daily?**_____

Do you drink alcohol? _____ **No** _____ **Yes** **How much daily?**_____

WOMEN Only: **Are you pregnant or planning pregnancy?** _____ **Yes** _____ **No**
Are you taking birth control pills? _____ **Yes** _____ **No**
Are you taking hormone replacement? _____**Yes** _____ **No**

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Rheumatic Fever…….	Y	N	Asthma…….	Y	N
Rheumatic Heart Disease……...	Y	N	Emphysema…….	Y	N
Congenital Heart Disease……..	Y	N	Bronchitis……	Y	N
Cardiovascular Disease…….	Y	N	Pneumonia……..	Y	N
Heart Attack……..	Y	N	Tuberculosis……	Y	N
Heart Murmur……..	Y	N	Seizures……	Y	N
Coronary Artery Disease…….	Y	N	Convulsions……..	Y	N
Angina……	Y	N	Epilepsy ……...	Y	N
High Blood Pressure…….	Y	N	Psychiatric Treatment…….	Y	N
Stroke…….	Y	N	Nervous Disorders……	Y	N
Palpitations……	Y	N	Bleeding Disorders……...	Y	N
Heart Surgery……	Y	N	Anemia……..	Y	N
Pacemaker…….	Y	N	Kidney Disease…….	Y	N
Liver Disease…….	Y	N	Diabetes……	Y	N
Jaundice ……	Y	N	Thyroid Disease……..	Y	N
Hepatitis……	Y	N	Arthritis ……..	Y	N
Stomach Ulcers/Colitis…….	Y	N	Glaucoma……	Y	N
Mouth Sores……..	Y	N	Radiation/Cancer ……..	Y	N
Implants (heart valve, knee, hip)…	Y	N	Sinus/nasal problems……..	Y	N
Clicking/Popping of jaw joint…….	Y	N	Pain near ear……	Y	N
Grind/clench teeth……	Y	N	Recurrent Infections……	Y	N

Do you have any other disease, condition or problem that you think the doctor should know about?

_____

Do you wish to speak privately about anything?_____

Signature:_____ **Date**_____