Health History DATE: _____

Have you been hospitalized in the last 5 years? YES NO
IF YES, please give reason:

_____

Cardiovascular Disease (heart trouble, heart attack, heart murmur, artificial heart valve, or mitral valve prolapse) YES NO

ARE YOU ON A BLOOD THINNER OR BABY ASPIRIN? YES NO

Pacemaker	YES	NO	HIV Positive or AIDS related complex	YES	NO
High Blood Pressure	YES	NO	Low Blood Pressure	YES	NO
Diabetes	YES	NO	Kidney Trouble or Dialysis	YES	NO
Hepatitis, any form	YES	NO	LATEX sensitivity or allergy	YES	NO
Artificial Joints	YES	NO	Liver Disease including Jaundice	YES	NO
Anemia	YES	NO	Psychosis or Anxiety Disorder	YES	NO
Arthritis	YES	NO	Sleep Apnea or use of C-pap	YES	NO
Asthma	YES	NO	Stomach or Intestinal Problem	YES	NO
Blood Disease	YES	NO	Stroke	YES	NO
Cancer	YES	NO	Thyroid Disorder	YES	NO
Emphysema	YES	NO	Tuberculosis	YES	NO
Epilepsy or Seizures	YES	NO	Radiation Therapy (Head or Neck)	YES	NO
Glaucoma	YES	NO	Do you use tobacco products?	YES	NO

Women: Are you currently pregnant? YES NO
Any condition that could require pre-medication (such as knee/hip replacement) YES NO

Known allergies to these medications (please circle): Penicillin, Sulfa, or "Mycins"? YES NO

Known allergies to any other drugs (please list): _____

Any other disease, condition, or problem NOT listed above that we should know about?

_____

Please list all medications you are currently taking, including prescriptions, over the counter medications and/or herbal remedies:
IF you have a personal prescription list, we will be happy to make a copy for you.

_____
_____
_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

PATIENT, PARENT OR GUARDIAN: _____ **DATE:** _____

Reviewed by Doctor: _____ **DATE:** _____

MEDICAL UPDATES

I have read my medical history dated _____ and confirm that it adequately states past & present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____
_____	_____	_____	_____	DR._____