Name:_____ **Date:**_____

Patient Health History:

Physicians Name: _____ Phone:_____

Are you allergic to any of the following?(please circle all that apply): Yes No

Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Latex Metals Dental Anesthetics Other_____

Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Respiratory Disease	☐	☐	Mitral Valve Prolapse	☐	☐	Dizziness/Fainting
☐	☐	Heart Disease	☐	☐	Asthma	☐	☐	Growths/Tumors	☐	☐	Epilepsy/Seizures
☐	☐	High Blood Pressure	☐	☐	Hay Fever	☐	☐	Chemotherapy	☐	☐	Mental Disorders
☐	☐	Low Blood Pressure	☐	☐	Allergies	☐	☐	Radiation Treatment	☐	☐	Nervous Disorders/Anxiety
☐	☐	Stroke	☐	☐	Sinus Trouble	☐	☐	Jaundice	☐	☐	Eating Disorders
☐	☐	Artificial Heart Valve	☐	☐	Diabetes Type:_____	☐	☐	Kidney Disease	☐	☐	Drug Addiction/Alcohol
☐	☐	Pacemaker	☐	☐	Blood Disease/Disorder	☐	☐	Liver Disease	☐	☐	Head Injuries
☐	☐	Blood Transfusion	☐	☐	HIV/AIDS	☐	☐	Menopause	☐	☐	Frequent Headaches
☐	☐	High Cholesterol	☐	☐	Herpes Lesions	☐	☐	Arthritis Type:_____	☐	☐	Acid Reflux
☐	☐	Bruise Easily	☐	☐	Ulcers	☐	☐	Excessive Bleeding	☐	☐	Hepatitis Type:_____
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Thyroid Type:_____	☐	☐	HPV Virus
☐	☐	Cold Sores	☐	☐	Cortisone Treatment	☐	☐	Chest Pain	☐	☐	Sleep Apnea

Joint Replacement: ☐Y ☐N Type:_____ Date: _____ **Pre-Med Required**:☐ Y ☐N

Cancer: ☐ Y ☐ N Type:_____ Date:_____Chemotherapy:☐Y ☐N Radiation: ☐Y ☐N

Do you have any other health problems or conditions? ☐YES ☐ NO

If yes, please explain: _____

Are you taking any medications or vitamins at this time? ☐YES ☐ NO

If yes, please list medications/vitamins below:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you been admitted to a hospital or needed emergency care during the past year? ☐ YES ☐ NO

If yes, please explain: _____

Are you now under the care of a specialist? ☐ YES ☐NO Name of Physician: _____

Do you smoke/use tobacco products? ☐YES ☐NO Type:_____ How much per day?:_____

WOMEN: ☐N/A

Are you pregnant or nursing? ☐ YES ☐NO Due Date: _____ **Are you taking birth control?** ☐ YES ☐ NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian:_____ **Date:** _____

Doctor Signature:_____ **Date:** _____