



HEALTH HISTORY INFORMATION

NAME _____ DATE _____

PLEASE CHECK THE BOXES THAT APPLY TO YOUR PAST AND CURRENT HEALTH CONDITIONS:

MEDICAL HISTORY

- ARTHRITIS
- PAINFUL/SWOLLEN JOINTS
- EYE PROBLEMS (GLAUCOMA)
- STOMACH ULCERS
- DIARRHEA
- CONSTIPATION
- VOMITING OR ACID REFLUX
- KIDNEY/BLADDER TROUBLE
- HEAD OR NECK INJURY
- BACK/NECK PAIN
- SHORTNESS OF BREATH
- HEADACHE/MIGRAINES
- SWOLLEN ANKLES
- PNEUMONIA
- CHRONIC COUGH
- FRACTURE OR DISLOCATION
- NUMBNESS OR TINGLING ANY WHERE
- THYROID PROBLEMS
- WEIGHT CHANGE OVER 20 LBS IN PAST YEAR
- ASTHMA, DATE OF LAST ATTACK _____

DISEASES/DISORDERS

- EXPOSED TO TUBERCULOSIS
- AIDS/HIV
- SKIN DISEASE
- DIABETES
- ANEMIA
- HEPATITIS/JAUNDICE
- LIVER DISEASE
- DEFECTIVE IMMUNE SYSTEM
- EPILEPSY/SEIZURES
- NEUROLOGIC DISORDER
- BRONCHITIS/EMPHYSEMA
- HORMONE REPLACEMENT
- OSTEOPOROSIS/THINNING BONES
- SEXUALLY TRANSMITTED DISEASE
- SLEEP APNEA/SNORING

CANCER

- CHEMOTHERAPY
- RADIATION THERAPY
- LEUKEMIA
- CANCER OR TUMOR

ALLERGIES

- FOOD
- LATEX
- METALS
- SEASONAL ALLERGIES
- LOCAL ANESTHETIC
- LIDOCAINE
- MEDICATIONS:

HEALTH CONCERNS

- SMOKING
- RECREATIONAL DRUGS OR SUBSTANCES
- RECOVERING SUBSTANCE ABUSER
- LUNG INFECTION
- VASCULAR SHUNT (FOR HEMODIALYSIS OR DRUG THERAPY)

HEART

- HEART DISEASE
- HEART INFECTION
- HEART MURMUR
- HEART TRANSPLANT
- HEART DEFECT
- HEART ATTACK
- ANGINA/CHEST PAIN
- PROSTHETIC HEART VALVE
- REPAIRED HEART DEFECT
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- PACEMAKER/DEFIBRILLATOR
- VASCULAR OR CARDIAC REPAIR

BLOOD

- BRUISE OR BLEED EASILY
- BLEEDING PROBLEMS
- STROKE

MENTAL

- DEPRESSED/BIPOLAR
- CHANGE IN MEMORY
- NERVOUS BREAKDOWN
- PANIC ATTACK
- PSYCHIATRIC CARE OR COUNSELING
- A.D.D./A.D.H.D.

SURGERIES

- IMPLANTS
- PROSTHETIC JOINTS
- ORGAN OR BONE MARROW TRANSPLANT
- OTHER _____

ORAL

- I HAVE HAD LOCAL ANESTHESIA
- I HAVE HAD GENERAL ANESTHESIA
- HURTS TO CHEW
- JAW MAKES CLICKING SOUND
- EAR ACHES

PREGNANCY

- NURSING
- IS IT POSSIBLE YOU ARE PREGNANT?
- YES
- NO
- IF YES, PLEASE INDICATE DUE DATE:

FIRST DAY OF YOUR LAST PERIOD:

MEDICATIONS

- BLOOD THINNERS
- MEDICINE FOR OSTEOPOROSIS
- FOSAMAX OR ACTONEL
- BIRTH CONTROL
- BLOOD PRESSURE MEDICINE
- CHOLESTEROL MEDICINE
- PLEASE LIST OTHER MEDICATIONS

OPTIONAL: RELIGIOUS PREFERENCE

PATIENT SIGNATURE
