

HEALTH HISTORY

NAME: _____ Age _____ Male _____ Female _____ Date of Birth ____/____/____

Have you ever had any serious illness, operation or been hospitalized within the last 5 years? Y or N

If you answered Y, please explain: _____

A. GENERAL

1. Medical Doctors Name: _____ Phone Number _____ Date of Last Physical: _____

Are you aware of any changes in your general health in the last year? Y or N Explain: _____

Are you currently under the care of a physician? Y or N For what condition _____

Do you or have you had any of the following conditions:

- Y or N Hearing Aid or Hearing Disorder?
- Y or N Diabetes? Family Member w/Diabetes?
- Y or N Hyperthyroidism, Hypothyroidism?
- Y or N Arthritis, Inflammatory Rheumatism?
- Y or N Venereal Disease?
- Y or N Epilepsy, Seizures, Fainting Spells?
- Y or N Ulcers?
- Women: Y or N Are You Pregnant? Month _____ Due Date: _____ Nursing? Y or N
- Y or N Impaired Eyesight, Glaucoma, Contact Lenses?
- Y or N Liver Condition, Jaundice, Hepatitis A, B, C, Cirrhosis?
- Y or N Kidney Condition, Renal Failure, Shunt, Dialysis?
- Y or N Do you have any Artificial Implants or Joint Implants? (Hip, screws, pins)
- Y or N Positive HIV, AIDS or AIDS Related Complex?
- Y or N Mouth Sores or Lesions?
- Y or N Cancer? Type: _____ Chemo or Radiation? Y or N

B. CIRCULATION: Do you or have you had any of the following conditions:

- Y or N Arteriosclerosis/Atherosclerosis?
- Y or N High, Low Blood Pressure?
- Y or N Blood Disorder, Anemia, Slow Clotting?
- Y or N Blood Transfusion? Year _____
- Y or N Other: _____
- Y or N Heart Surgery, Bypass Surgery, Valve Replacement?
- Y or N Rheumatic Fever, Rheumatic Heart Disease, Scarlet Fever?
- Y or N Congenital Heart Lesions, Heart Murmur, Mitral Valve Prolapse?
- Y or N Pace Maker, Artificial Valves, Shunts, Vessels?
- Y or N Chest Pain Upon Exertion – Ankles Swell?
- Y or N Heart Trouble, Heart Attack, Angina (Chest Pain)?

C. RESPIRATORY: Do you or have you had any of the following conditions:

- Y or N Chronic Lung Disease:
- Y or N Asthma?
- Y or N Hay Fever?
- Y or N Emphysema?
- Y or N Do You Currently Use Tobacco Products? If Yes, How Much: _____
- Y or N Night Sweats, Fever, Unexplained Weight Loss?
- Y or N Tuberculosis? Ever Exposed to TB or Family Member w/TB?
- Y or N Persistent Cough, Cough Up Blood?
- Y or N Sinus Trouble?

D. DRUGS AND MEDICINE: Any allergic reaction to:

- Y or N Aspirin?
- Y or N Erythromycin?
- Y or N Tetracycline?
- Y or N Sedatives
- Y or N Dental Anesthetic?
- Y or N Latex?
- Y or N Penicillin?
- Y or N Sulfa Drugs?
- Y or N Codeine or Pain Medication?
- Y or N Any other Medications or Antibiotics?

Are you taking any of the following:

Y or N Prescription Drugs? Please List: _____

Y or N Over-The-Counter Drugs? Please List: _____

Y or N Oral Contraceptives or Other Hormonal Therapy? Please List: _____

Y or N Have you or are you being treated for any drug or alcohol addiction?

Y or N Have you or are you being treated for problems with mental health?

Vital Signs: BP: _____

RESP: _____

PULSE: _____

List Other Allergies (Food, Metals, Etc.,) or Illness: _____

I certify all of the above information is correct and authorize its' release as required for the administration of my treatment.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Today's Date: _____

DR.'S SIGNATURE

Today's Date: _____

