HEALTH HISTORY

(Confidential)

The following information is very important to your health and will better allow our practice to serve you.
Please take your time to fill out form completely.

Name: _____ DOB: _____ Age: _____
Height: _____ Weight: _____ Gender: ❑ Male ❑ Female

ALLERGIES

Are you allergic to any medicines (including any tape, iodine or latex)

❑ No ❑ Yes (If yes, please complete the allergy information below)

Medication Allergic to	Type of Reaction you experience

PAST SURGICAL HISTORY

Type of Operation	Date of Operation

CURRENT MEDICATIONS

Medication	Dose	Frequency		Medication	Dose	Frequency

SOCIAL HISTORY

	Yes	No	
Do you smoke?	❑	❑	If yes, how much per day and how many years? _____
Have you ever smoked?	❑	❑	If yes, start date/quit date? _____
Do you drink alcohol?	❑	❑	If yes, how much and how often? _____
Do you do street/unprescribed drugs?	❑	❑	If yes, please specify. _____

Date of your last Tetanus Shot? _____

MEDICAL HISTORY (Please check only if a history exists for yourself or a family member)

	Self	Family	Relationship to you
Arthritis	❑	❑	_____
Asthma	❑	❑	_____
Blood Disorder	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Gastrointestinal	❑	❑	_____
Genitourinary/Prostate	❑	❑	_____
Heart Problems	❑	❑	_____
High Blood Pressure	❑	❑	_____
High Cholesterol	❑	❑	_____

Women	Yes	No	Last Menses:
Pregnant	❑	❑	_____
Hysterectomy	❑	❑	

	Self	Family	Relationship to you
Kidney Problems	❑	❑	_____
Liver Problems/Hepatitis	❑	❑	_____
Lung Problems	❑	❑	_____
Neuro: Seizures, Epilepsy	❑	❑	_____
Psychiatric	❑	❑	_____
STD	❑	❑	_____
Skin Disorders	❑	❑	_____
Thyroid	❑	❑	_____
Other	❑	❑	_____

Patient/Guardian Signature _____ Today's Date _____

(The information provided on this form is true and correct to the best of my belief)