

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?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much per day and how many years? _____
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, start date/quit date? _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much and how often? _____
Do you do street/unprescribed drugs?	<input type="checkbox"/>	<input type="checkbox"/>	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		Self	Family	Relationship to you
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Problems/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuro: Seizures, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____	STD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary/Prostate	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Women

	Yes	No	Last Menses: _____
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient/Guardian Signature _____ Today's Date _____

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