Patient Health History Form

We periodically request that you fill out a new health history form so we may be aware of any changes in your health. This helps us to provide you with better care.

Your Name_____

Physician's Name **(medical)**_____Date of last **medical** visit_____

Have you ever had a blood transfusion? If so please list the approximate date_____

Women Are you pregnant? _____ Nursing? _____ Taking birth control?_____

Please circle if you have had any of the following:

Anemia	Cortizone Treatments	Hepatitis
Arthritis, Rheumatism	Cough, Persistent	High Blood Pressure
Artificial Heart Valves	Cough up Blood	HIV/AIDS
Artificial Joints	Diabetes	Jaw Pain
Asthma	Epilepsy	Kidney Disease
Back Problems	Fainting	Liver Disease
Blood Disease	Glaucoma	Mitral Valve Prolapse
Cancer	Headaches	Pacemaker
Chemical Dependency	Heart Murmur	Radiation Treatment
Chemotherapy	Heart Problems	Respiratory Disease
Circulatory Problems	Hemophilia	Aniety
Scarlet/Rheumatic Fever	Shortness of Breath	Skin Rash
Stroke	Swelling of Feet or Ankles	Anaphylaxis
Thyroid Problems	Tobacco Habit	Tonsillitis
Tuberculosis	Ulcer	COPD
Open Heart Surgery	Depression	Emphysema
Bipolar	Schizophrenia	

Please list dates and details of any surgeries or serious health problems in detail_____

_____

Current Medications Including Vitamins and Supplements_____

_____

Drug Allergies_____

If you have had a change of address or phone number, please write it below.

_____

_____

Signature_____