Patient's Health History

Please Print

Please answer all of the questions as accurately as possible.

Patient Name: _____
Last First MI

Patients Date of Birth:_____

Health History

Current Medications: *(circle all that apply and list product name and milligrams.)*

Non-steroidal anti-inflammatory or pain medication: _____
Antidepressants: _____
Anti-seizure medication: _____
Aspirin: _____
Blood pressure medication: _____
Blood thinners: _____
Herbals: _____
Insulin: _____
Weight Reduction medication: _____

Other: _____

Conditions/Illnesses: *(do you or have you -- circle all that apply.)*

Cancer: _____
Cardiovascular: Heart Attack/Disease
Depression
Endocrine: Diabetes / Thyroid
Gastrointestinal
Hematologic: Easily bruised / Excessive bruising
Infectious Disease: Cold Sores / Herpes
Hepatitis
HIV/AIDS
Liver Disease
Psychiatric
Renal Disease: Kidney Disease
Respiratory: Asthma
Stroke
Other: _____

Allergies and Reactions: *(please provide reaction and name of allergen if known)*

Medications: _____
Latex: _____
Other: _____
Chemicals: _____
Products: _____

List previous surgeries/Major Illness and Dates:

Hospitalizations: _____
Operations: _____
Serious illness or injuries: _____
Other:

_____

Family History: *(has any blood relative ever had the following?)*

Cancer (type): _____
Diabetes: _____
Heart attack/disease: _____
High blood pressure: _____
Skin cancers: _____
Stroke: _____

Social History

Alcohol Use:

Do you drink alcohol? Yes No Number of drinks / weekly: _____

Cigarette Use:

Do you smoke cigarettes? Yes No Packs/Day: _____