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 H	istory		
Current Medications: (circle all that apply and list p	product name a	and milligrams.)	
Non-steroidal anti-inflammatory			
or pain medication:	Blood	thinners:	
Antidepressants:	Herbals:		
Anti-seizure medication:	Insul	in:	
Aspirin:	Weigl	nt Reduction medication:	
Other:			
Conditions/Illnesses: (do you or have you circle			
Cancer: Cardiovascular: Heart Attack/Disease	T *	er Disease	
Depression		r Disease chiatric	
Endocrine: Diabetes / Thyroid	Pay	nal Disease: Kidney Disease	
Gastrointestinal	Dog	spiratory: Asthma	
Hematologic: Easily bruised / Excessive bruising		oke	
Infectious Disease: Cold Sores / Herpes		ner:	
Hepatitis	Oti	iei	
HEPAUUS HIV/AIDS			
Allergies and Reactions: (please provide reaction a Medications:	_ Chem _ Prode	icals: ucts:	
other.			
List previous surgeries/Major Illness and D			
Hospitalizations:			
Operations:			
Serious illness or injuries:			
Other:			
Family History: (has any blood relative ever had t	he following?	")	
Cancer (type):		gh blood pressure:	
Diabetes:	_ Sk	in cancers:	
Heart attack/disease:		roke:	
Social His	<u>tory</u>		
Alcohol Use:	ū		
Do you drink alcohol? Yes No	Number of d	Jumber of drinks / weekly:	
Cigarette Use:			
Do you smoke cigarettes? Yes No	Packs/Dav:		