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Health History

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Please mark each question individually. A line through "no" will not be sufficient.

Anemia *	◯ Yes ◯ No	Anxiety / Depresison *	◯ Yes ◯ No
Arthritis *	◯ Yes ◯ No	Artificial Joints *	◯ Yes ◯ No
Asprin Allergy *	◯ Yes ◯ No	Asthma *	◯ Yes ◯ No
Azithromycin Allergy *	◯ Yes ◯ No	Bleeding Disorder *	◯ Yes ◯ No
COPD *	◯ Yes ◯ No	Cancer *	◯ Yes ◯ No
Clindamycin Allergy *	◯ Yes ◯ No	Codeine Allergy *	◯ Yes ◯ No
Dementia *	◯ Yes ◯ No	Diabetes *	◯ Yes ◯ No
Dizziness *	◯ Yes ◯ No	Eating Disorders *	◯ Yes ◯ No
Epilepsy *	◯ Yes ◯ No	Erythromycin Allergy *	◯ Yes ◯ No
Fainting *	◯ Yes ◯ No	Glaucoma *	◯ Yes ◯ No
HIV / STDs *	◯ Yes ◯ No	Head Injuries *	◯ Yes ◯ No
Headaches *	◯ Yes ◯ No	Heart Disease *	◯ Yes ◯ No
Heart Failure *	◯ Yes ◯ No	Heart Valve Prolapse *	◯ Yes ◯ No
Hepatitis *	◯ Yes ◯ No	High Blood Pressure *	◯ Yes ◯ No
Iodine Allergy *	◯ Yes ◯ No	Jaundice *	◯ Yes ◯ No
Kidney Disease *	◯ Yes ◯ No	Latex Allergy *	◯ Yes ◯ No
Liver Disease *	◯ Yes ◯ No	Low Blood Pressure *	◯ Yes ◯ No
Migraines *	◯ Yes ◯ No	NSAID Allergy *	◯ Yes ◯ No
Nervous Disorders *	◯ Yes ◯ No	Osteoporosis *	◯ Yes ◯ No
Other *	◯ Yes ◯ No	Pacemaker *	◯ Yes ◯ No
Parkinson's *	◯ Yes ◯ No	Penicillin Allergy *	◯ Yes ◯ No
Pregnancy *	◯ Yes ◯ No	Prosthetic Valve *	◯ Yes ◯ No
Radiation Treatment *	◯ Yes ◯ No	Respiratory Problems *	◯ Yes ◯ No
Rheumatic Arthritis *	◯ Yes ◯ No	Rheumatic Fever *	◯ Yes ◯ No
Sinus Problems *	◯ Yes ◯ No	Stomach Problems *	◯ Yes ◯ No
Stroke *	◯ Yes ◯ No	Sulfa Allergy *	◯ Yes ◯ No
Thyroid Conditions *	◯ Yes ◯ No	Tuberculosis *	◯ Yes ◯ No
Ulcers *	◯ Yes ◯ No		

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

I attest that I have provided a complete medical history and hold the practice harmless from complications that may occur due to undisclosed medical conditions.

Signature _____ **Date** _____

Response Date: _____