

Health History Form

E-mail	Today's Date
<input type="text"/>	<input type="text"/>

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PERSONAL INFORMATION

First Name	Last Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>

If you are completing this form for another person, what is your relationship to that person?

Your Name	Relationship
<input type="text"/>	<input type="text"/>

Home Phone	Cell Phone
<input type="text"/>	<input type="text"/>

MEDICAL INFORMATION

For the following questions, please mark (X) your responses.

Are you currently under the care of a physician?..... Yes No

Physician Name Phone

Address/City/State/Zip

Are you in good health?..... Yes No

Has there been any change in your general health within the past year?..... Yes No

If yes, what condition is being treated?

Date of last physical exam

For the following questions mark (x) your responses

Do you use controlled substances (drugs)?..... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)?..... Yes No

If so, how interested are you in stopping?
 VERY SOMEWHAT NOT INTERESTED

Do you drink alcoholic beverages?..... Yes No

If yes, how much alcohol did you drink in the last 24 hours?

Joint Replacement: Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... Yes No

If yes, date If yes, have you had any complications?

Allergies: Are you allergic or have you had a reaction to:

Local anesthetics..... Yes No

Aspirin..... Yes No

Penicillin or other antibiotics..... Yes No

Barbiturates, sedatives, or sleeping pills..... Yes No

Sulfa drugs..... Yes No

Codeine or other narcotics..... Yes No

Have you had a serious illness, operation or been hospitalized in the past 5 years?..... Yes No

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... Yes No

Do you take any blood thinners?..... Yes No

Do you take aspirin on a regular basis?..... Yes No

If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

WOMEN ONLY Are you:

Pregnant?..... Yes No

Number of weeks

Taking birth control pills or hormonal replacements?..... Yes No

Nursing?..... Yes No

Yes No

Metals..... Yes No

Latex (rubber)..... Yes No

Iodine..... Yes No

Hay fever/seasonal..... Yes No

Animals..... Yes No

Food/Other..... Yes No

If yes, please specify

MEDICAL INFORMATION (Continued)

Please mark (X) your response if you have or have had any of the following diseases or problems.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes type I or type II..	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date			Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify		
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>				Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease...	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	GE Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type of infection		
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>			
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease...	<input type="checkbox"/>	<input type="checkbox"/>	Systematic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice, or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache/migraines..	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells/seizures....	<input type="checkbox"/>	<input type="checkbox"/>	Severe/rapid weight loss...	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	STDs/STIs.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects...	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify			Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Radiation treatment.....	<input type="checkbox"/>	<input type="checkbox"/>				ADD.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease...	<input type="checkbox"/>	<input type="checkbox"/>							ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion..	<input type="checkbox"/>	<input type="checkbox"/>	Gag Reflex Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Processing Disorder.	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Oral Sensory Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>

Has a physician recommended that you take antibiotics prior to your treatment?..... Yes No

Do you have any disease, condition, or problem not listed above that you think I should know about?..... Yes No

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address

