Health History Form

Name: ____Birth Date:______/_____/_____

Name of physician: ____Phone #: _______________

Date of last physical: _____/_____/_____ Are you in good health? Yes No

Have there been any changes in your health within the last year? Yes No

If yes, what condition is being treated? ____

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

If yes, what was the illness or procedure? ______________________________________

Are you taking or have you recently taken any prescriptions and/or diet/herbal supplements? Yes No

If yes, please list (including vitamins): ____

____

____

Do you now or have you ever used tobacco products? Yes No If yes, how often? _______________

Do you now or have you ever used Marijuana, Cocaine or other drugs? Yes No

Do you use alcohol regularly? Yes No If yes, how much daily? __________________________

Are you recovering from drug/alcohol addiction? Yes No

Are you allergic or had a reaction to any of the following?

Local anesthetic like Lidocaine?	Yes No	Aspirin?	Yes No
Penicillin?	Yes No	Latex?	Yes No

Other? Please explain ____

Do you have or have you ever had:

Heart Condition	Yes No	Lupus	Yes No
Heart Murmur	Yes No	Hepatitis, jaundice or liver disease	Yes No
Mitral Valve Prolapse	Yes No	Lung or breathing problems	Yes No
Heart Attack	Yes No	Asthma	Yes No

Heart Surgery	Yes No		Tuberculosis (TB)	Yes No
Stroke	Yes No		Fainting Spells	Yes No
Rheumatic Fever	Yes No		Epilepsy/seizures	Yes No
Scarlet Fever	Yes No		Diabetes	Yes No
Angina	Yes No		Kidney trouble	Yes No
Pacemaker	Yes No		Cancer, tumors, growths	Yes No
High Blood Pressure	Yes No		Leukemia	Yes No
AIDS/HIV Infection	Yes No		Radiation therapy	Yes No
Pins, screws, plates	Yes No		Chemotherapy	Yes No
Joint, knee or hip replacement	Yes No		Abnormal bleeding	Yes No
Anemia	Yes No			
Have you taken Bisphosphonates?	Yes No			

Do you have or have you had any serious condition or disease NOT listed on this form? Yes No

If yes, please explain ____

Women only:

Are you pregnant or think you may be pregnant Yes No

Are you nursing? Yes No

Are you on birth control of any type? Yes No

By signing below I certify that the information above is accurate to the best of my knowledge.

Patient/guardian signature: ____Date: _______________