Health History

Name:____**Your Age:**____________

I. Please Circle the Appropriate Answer:

1. Is your general health good? Yes No

2. Have you been hospitalized or had a serious illness in the last three years?
Yes No Why? ____

3. What was the date of your last medical exam / Doctor's name?
____

4. Do you take medication (including aspirin)? Yes No
Please list medications: ____

II. Do you have, or have you had, any of the following?

High Blood Pressure	Yes	No	Allergies to Medication	Yes	No	If so, what ________
Heart Murmur	Yes	No	Allergies to Anesthesia	Yes	No	If so, what ________
Rheumatic Fever	Yes	No	Artificial Joint	Yes	No	
Heart Defects	Yes	No	Prosthetic Heart Valve	Yes	No	
Chest Pain	Yes	No	Heart Disease	Yes	No	
HIV/AIDS	Yes	No	Heart Attack	Yes	No	
Headaches	Yes	No	Seizures	Yes	No	
Stroke	Yes	No	Dry Mouth	Yes	No	
Sinus Problems	Yes	No	Pacemaker	Yes	No	
Asthma	Yes	No	Seasonal Allergies	Yes	No	
Tuberculosis	Yes	No	Lung Disease/COPD	Yes	No	
Diabetes	Yes	No	Stomach Ulcers	Yes	No	
Chemotherapy	Yes	No	Cancer	Yes	No	
Bleeding Problems	Yes	No	Radiation Treatment	Yes	No	
Kidney Disease	Yes	No	Hepatitis/Liver Disease	Yes	No	
Psychiatric Care	Yes	No	Thyroid Problems	Yes	No	
Arthritis	Yes	No	Fainting Episodes	Yes	No	
Prosthetic Heart Valve	Yes	No	Drug Use or History of Abuse	Yes	No	
Mitral Valve Prolapse	Yes	No	Congestive Heart Failure	Yes	No	

III. Women Only:

Are you pregnant or nursing? Yes No Unsure

Are you taking birth control pills? Yes No

<u>Women taking birth control medications should be aware that antibiotics can cause the birth control medications to be ineffective possibly resulting in pregnancy.</u>

I understand that the information I have given today is correct to the best of my knowledge.

Signature: ____ **Date:** ____________

Signature (Doctor): ___________________________________ **Date:** ____________