PATIENT_____

PLEASE CHECK ALL CURRENT OR PAST CONDITIONS THAT APPLY (*THERE MUST BE A CHECK IN EACH SECTION*)

HEALTH HISTORY

HEART

☐ **ARTIFICIAL HEART VALVE**
☐ RHEUMATIC FEVER
☐ ANGINA PECTORIS
☐ HEART SURGERY
☐ SCARLET FEVER
☐ HIGH BLOOD PRESSURE
☐ **ENDOCARDITIS**
☐ MITRAL VALVE PROLAPSE
☐ RHEUMATIC HEART DISEASE
☐ HEART ATTACK
☐ HEART FAILURE
☐ HISTORY OF PHEN-FEN USE
☐ LOW BLOOD PRESSURE
☐ OTHER
☐ HEART MURMUR
☐ PACEMAKER
☐ CONGENITAL HEART DISEASE
☐ HEART PROBLEMS
☐ CHEST PAIN
☐ SWELLING OF ANKLES
☐ NONE OF THESE APPLY

_____
_____

RESPIRATORY

☐ EMPHYSEMA
☐ PERSISTENT COUGH
☐ TOBACCO USE
☐ TUBERCULOSIS
☐ CHRONIC BRONCHITIS
☐ OTHER
☐ ASTHMA
☐ SHORTNESS OF BREATH
☐ NONE OF THESE APPLY

_____
_____

CIRCULATORY SYSTEM

☐ HEMOPHILIA
☐ FREQUENT NOSEBLEEDS
☐ SICKLE CELL ANEMIA
☐ BLOOD TRANSFUSIONS
☐ EXCESSIVE BLEEDING
☐ **TAKING BLOOD THINNERS**
☐ CLOTTING PROBLEMS
☐ BRUISES EASILY
☐ OTHER
☐ NONE OF THESE APPLY

_____
_____

DIGESTIVE SYSTEM

☐ LIVER DISEASE
☐ STOMACH ULCERS
☐ ACID REFLUX
☐ OTHER
☐ HEPATITIS-TYPE _____
☐ ULCERS
☐ IRRITABLE BOWEL SYNDROME
☐ YELLOW JAUNDICE
☐ BLACK, BLOODY STOOLS
☐ COLITIS
☐ NONE OF THESE APPLY

_____
_____

NEUROLOGICAL SYSTEM

☐ EPILEPSY ☐ SEIZURES ☐ FAINTING/DIZZY SPELLS ☐ STROKE
☐ OTHER ☐ CHRONIC HEADACHES ☐ NONE OF THESE APPLY

_____
_____

ENDOCRINE SYSTEM

☐ THYROID DISEASE
☐ CIRCULATION PROBLEMS
☐ OTHER
☐ DIABETES
☐ FAMILY HISTORY OF DIABETES
☐ DELAYED HEALING
☐ NONE OF THESE APPLY

_____
_____

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AUTOIMMUNE DISEASE

☐ LUPUS ☐ SJROGEN'S ☐ RHEUMATOID ARTHRITIS
☐ AIDS ☐ HIV POSITIVE ☐ OTHER ☐ NONE OF THESE APPLY

_____
_____

ALLERGIC TO:

☐ ANESTHETICS ☐ FOODS ☐ DRUGS ☐ LATEX ☐ METALS

☐ ANTIBIOTICS ☐ HAY FEVER/AIRBORNE ☐ OTHER ☐ NONE OF THESE APPLY

_____
_____

URINARY

☐ KIDNEY TROUBLE/DISEASE ☐ INCREASED FREQUENCY OF URINATION
☐ BLOOD IN URINE ☐ OTHER ☐ NONE OF THESE APPLY

_____
_____

PSYCHOLOGICAL

☐ DEPRESSION ☐ PSYCHIATRIC TREATMENT ☐ DRUG ADDICTION
☐ ALCOHOL ADDICTION ☐ ALCOHOL USE ☐ OTHER ☐ NONE OF THESE APPLY

_____
_____

GENERAL

☐ **ARTIFICIAL JOINTS** ☐ CANCER ☐ TUMORS ☐ CHEMOTHERAPY
☐ PREGNANT-DUE DATE _____ ☐ HERPES ☐ COLD SORES/FEVER BLISTERS
☐ VENEREAL DISEASE ☐ BIRTH CONTROL ☐ PROSTHETIC IMPLANTS
☐ NIGHT SWEATS ☐ UNEXPLAINED WEIGHT GAIN/LOSS ☐ HIVES
☐ SKIN RASHES ☐ ANY OTHER HEALTH ISSUES ☐ NONE OF THESE APPLY

PLEASE LIST ANY CONDITION YOU HAVE THAT IS NOT ADDRESSED IN THE ABOVE LISTS

_____
_____
_____

PLEASE LIST (OR ATTACH LIST OF) ALL CURRENT MEDICATIONS (BOTH PRESCRIPTION & OVER THE COUNTER)

_____
_____
_____

YR 1_____
PATIENT/GUARDIAN TODAY'S DATE DR. INT

YR 2 _____
PATIENT/GUARDIAN ☐ NO CHANGES ☐ NOTE CHANGES DATE
DR.INT

YR 3 _____
PATIENT/GUARDIAN ☐ NO CHANGES ☐ NOTE CHANGES DATE
DR.INT

REVISED 7/2009
OVER