PATIENT NAME _____PHONE_____

ADDRESS_____

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

## HEALTH HISTORY

### HEART

☐ ARTIFICAL HEART VALVE
☐ RHEUMATIC FEVER
☐ ANGINA PECTORIS
☐ HEART SURGERY
☐ SCARLETT 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
☐ HIGH CHOLESTROL
☐ CHEST PAIN
☐ ANKLE SWELLING
☐ NONE OF THESE APPLY

NOTES:_____
_____

### RESPIRATORY

☐ EMPHYSEMA
☐ PERSISTENT COUGH
☐ TOBACCO
☐ NONE OF THESE APPLY
☐ TUBERCULOUS
☐ CHRONIC BROCHITIS
☐ VAPE USE
☐ ASTHMA
☐ SHORTNESS OF BREATH
☐ OTHER

NOTES:_____
_____

### CIRCULATORY SYSTEM

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

NOTES:_____
_____

### DIGESTIVE SYSTEM

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

NOTES:_____
_____

### NEUROLOGICAL SYSTEM

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

NOTES:_____
_____

### ENDOCRINE SYSTEM

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

NOTES:_____
_____

AUTOIMMUNE DISEASE

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

NOTES:_____
_____

ALLERGIES

☐ ANESTHETICS ☐ FOODS ☐ LATEX
☐ ANTIBIOTICS ☐ DRUGS ☐ METALS
☐ HAY FEVER AIRBOURNE ☐ OTHER ☐ NONE OF THESE APPLY

NOTES:_____
_____

URINARY

☐ KIDNEY TROUBLE ☐ INCREASE FREQUENCY ☐ BLOOD IN URINE
☐ OTHER ☐ NONE OF THESE APPLY

NOTES:_____
_____

PSYCHOLOGICAL

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

NOTES:_____
_____

GENERAL

☐ **ARTIFICAL JOINTS _____** ☐ HIVES ☐ TUMORS
☐ PREGNANT-DUE _____ ☐ HERPES ☐ CHEMOTHERAPY
☐ VENEREAL DISEASE ☐ BIRTH CONTROL ☐ COLD SORES/FEVER BLISTERS
☐ NIGHT SWEATS ☐ OSTEOPOROSIS/PENIA ☐ PROSTHETIC IMPLANTS
☐ SKIN RASHES ☐ UNEXPLAINED WEIGHT - / + ☐ OTHER
☐ CANCER TYPE _____ DIAG DATE_____ ☐ NONE OF THESE APPLY

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

_____
_____
_____

**PLEASE LIST OR ATTACH A LIST OF ALL CURRENT MEDICATIONS BOTH PRESCRIBED AND OVER THE COUNTER**

_____
_____
_____

YR 1 _____
PATIENT/GUARDIAN SIGNATURE DATE DR INITIALS

YR 2 _____
PATIENT/GUARDIAN SIGNATURE DATE DR INITIALS
☐ NO CHANGES ☐ NOTE CHANGES _____

YR 3 _____
PATIENT/GUARDIAN SIGNATURE DATE DR INITIALS
☐ NO CHANGES ☐ NOTE CHANGES _____